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‘Facing choices’: A mixed-methods approach to patients’ experience of care and discharge in an inpatient mental health unit.

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Acknowledgements

"What is written without effort is in general read without pleasure."

Samuel Johnson, author and lexicographer (1709-1784)

Assuming a direct correlation between effort and pleasure, y'all are in for the time of your lives! Seriously though, the effort that has gone into this project has not been solely mine. Credit goes to my supervisors Mike and Matthias for all their input; to my Mum for balancing head cheerleader and honest critic roles with her usual skill; to my Dad, nature/nurture source of the sheer bloody-mindedness that it took see this through; to every friend who ever listened to me whinge and grump, especially Faye and Lucy who still have this to come and thus could probably have done without it. Most of all credit goes to Kit, who has been willing to 'man up' and take on all the domestic and personal responsibilities that I have been steadily shedding over recent months, and who has just plain *put up with me* for the last four years despite having known exactly what was coming. Cheers.

Contents

Thesis Abstract

Objectives: This thesis addresses patients' conceptualising of the experience of admission to and discharge from an inpatient mental health unit, and the role of measurable psychosocial constructs in this conceptualisation.

Design: An embedded mixed-methods design was employed. Themes developed using thematic analysis were compared and contrasted with standardised assessment ratings.

Methods: Twelve adult patients of an acute mental health unit took part in two separate interviews about their experience of admission and discharge, and completed standardised measures of anxiety and depression, social support, attachment style and illness beliefs. Interview data were analysed using social constructionist thematic analysis. Relationships between participants' contribution to constructed themes and their responses to standardised assessments were discussed in the context of extant literature.

Results: A total of fourteen themes were constructed, organised around a central theme of choices, planning and decision making. Many themes were comparable to existing constructs in attachment theory and the literature addressing illness appraisal, including mentalisation, the safe haven, internal working models, self as illness and shame. Standardised assessments supported and enhanced these interpretations.

Conclusions: Understanding of the process and adaptation to the inpatient experience can be enhanced by reference to the concepts of attachment theory and social cognition. Incorporation of these concepts into current care practices and future service development may improve the inpatient experience.

Chapter 1: Systematic review.

Presented in accordance with Instructions for Contributors to Psychological Medicine (see Appendix 1).

5,525 words (excluding abstract, references, tables and appendices).

Are psychological measures at discharge from inpatient psychiatric care associated with outcomes at follow up? A systematic review.

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Abstract:

Background: Providing targeted community care to prevent readmissions to inpatient psychiatric care is a key National Health Service policy, requiring accurate identification of individuals at risk of readmission. Current risk assessment algorithms comprise mainly admission and demographic variables. Inclusion of psychological variables may incrementally improve their predictive power. This article systematically reviews the literature to evaluate the evidence that psychological variables at discharge from inpatient mental health care are associated with outcomes at follow-up.

Methods: Databases Medline, Psychinfo and CINAHL were searched for articles published in English between 2003 and 2010 with keywords 'mental health', 'inpatient', 'discharge' and 'follow-up' or related terms. Exclusion criteria identified studies administering psychological measures at discharge from inpatient psychiatric care and investigating relationships with outcomes post-discharge. Fifteen studies were retained. Study quality was appraised using the Method for Evaluating Research and Guideline Evidence.

Results: A narrative review of findings is presented. Studies varied in sample population, measures, follow-up period and analytic approach. No two were directly comparable. Four studies found no relationship between psychological measures at discharge and outcomes at follow-up. Eleven found statistically significant links, but consistency between findings was low.

Conclusion: Findings do not support the administration of psychological measures at discharge from inpatient psychiatric care for the purpose of predicting long term outcomes.

Introduction

Providing effective, targeted community care to prevent inappropriate readmissions to inpatient psychiatric care is an explicit policy of the National Health Service (NHS) in Scotland (Scottish Executive, 2006, 2007). This requires accurate identification of individuals most at risk of readmission and other negative outcomes (Information Services Division, 2009).

Associations with outcomes among patients discharged from inpatient care have previously been reviewed. Troister *et al.* (2008) reviewed 28 studies investigating predictors of suicide within 1 year of discharge. Predictors clustered into three categories; suicidality, patient care, and demographic and psychopathological factors. Patients with a history of self-harm or suicidal ideation; who were unemployed, had little social support or recent negative life events; and patients who had shorter hospital stays, unplanned discharge, or were non-compliant with treatment were at greater risk of suicide. Kallert *et al.* (2008) reviewed 41 studies comparing voluntarily to involuntarily admitted patients. Involuntary admission was associated with similar lengths of stay, readmission rates, psychopathology, treatment compliance and mortality, but with higher rates of suicide and lower social functioning and treatment satisfaction. The findings of Steffen *et al.* (2009) 'cautiously' support discharge planning; their review of 11 studies indicated a modest association with reduced readmission rates and increased adherence to outpatient treatment. Durbin *et al.* (2007) examined the relationship between quality of care variables and early readmission, assessed by 13 studies. They concluded the relationship was 'unclear', calling into question the conclusions of studies taking rate of or time to readmission as an outcome variable for service evaluation.

Reviewers commented on difficulties assimilating studies, noting variability in methods and inconsistent operationalising of variables. They additionally noted the paucity of relevant trials (Durbin *et al*., 2007; Steffen *et al*., 2009), their predominantly retrospective design (Troister *et al*., 2008), small samples (Steffen *et al*., 2009) and small effect sizes (Kallert *et al*., 2008). Regarding the reviews themselves one observes a focus on 'administrative' variables pertaining to the hospitalisation rather than clinical variables pertaining to the patient.

Risk assessment algorithms have a similar administrative focus. The Scottish Patients at Risk of Readmission and Admission (to psychiatric hospitals or units) (SPARRA-MD; Information Services Division, 2009) incorporates six predictive variables; age; number of psychiatric admission in past three years; time since most recent admission; total number of bed days in past three years; urban/rural (residence) and principal diagnosis. The algorithm has 'acceptable' predictive power (area under ROC curve = 0.744; p.11). Conspicuous by their absence though are any 'psychological'[1] factors, for example psychological symptom severity, cognitive or psychosocial functioning. Neither were these represented in variables excluded from the algorithm by stepwise regression. There is a substantial body of past research linking psychological factors to outcomes following an episode of severe or enduring mental illness. Fenton and McGlashan (1987) found that people in sustained remission following first-episode schizophrenia were distinguishable by higher psychosocial functioning and higher depression scores at time of admission, while Wykes *et al.* (1990) found that better performance on a reaction-time task predicted movement to more independent care settings over a three year period. Though relatively few studies specifically address the period post-discharge from inpatient care (though see for examples Geddes et al, 1994; Craig *et al.* 2000)., the validity of both cognitive and affective/emotional measures as prognostic indicator within the clinical population has been frequently replicated (e.g. Wykes *et al.* 1992; Norman *et al.*1999).

There may be valid reasons for emphasising admission and demographic variables (e.g. Montgomery & Kirkpatrick, 2002, cited in Durbin *et al.,* 2007). Such information is easily accessed via routinely maintained records. It does not require patients to complete additional measures. Furthermore measurement is typically valid and reliable; a person is readmitted or they are not. The presence of, for example, insight into illness, may vary with the measure, information source - e.g. self- versus clinician report - and time of administration. This latter point is important: since one function of admission is to stabilise or improve mental state and psychosocial functioning (e.g. Bowers *et al.*, 2009), it is likely that such factors will vary during admission. Therefore reviews of research must take into account the timing of measurement (in this study the point of discharge was specified, as offering the most recent information)

[1] 'of, affecting, or arising in the mind; related to the mental and emotional state of a person', (Fowler *et al.,* 2009)

Reviews need also take into account the timing of the research project. Recent decades have seen a dramatic decrease in the number of psychiatric beds available in the developed world (e.g. Salokangas *et al.* 2007; Weich 2008) with inpatient care now restricted and reserved for acute risk management rather than long term rehabilitative treatment (e.g. Bowers *et al.* 2009). Demand for beds means the decision to discharge may be influenced by the relative needs of other patients as well as those of the patient in question, and that discharge is likely to be rapid and/or unplanned, and to take place immediately on crisis resolution rather than following extensive treatment (Mental Health Act Commission, 2006). As a result, patients being discharged in 2010 may not be directly comparable to those discharged in 1990 or even 2000.

Despite potential difficulties, psychological measures may incrementally improve the power of outcome prediction tools. An early step in establishing this is to survey the existing, recent literature. This systematic review addresses the question: *What is the evidence that psychological factors at discharge from inpatient mental health care are associated with outcomes at follow-up?*

Method

The review was conducted in accordance with guidelines in Petticrew and Roberts (2006), with additional guidance from Glasziou *et al.* (2001) and Greenhalgh (2010). A visual representation of the search process is given in Figure 1. As this review is exploratory and the concepts broadly defined, search terms were selected to capture a broad range of articles. Key terms (*psychiatric*, *inpatient*, *discharge* and *follow-up*) were identified and synonyms or specifiers (identified using the 'Related Terms' function of OvidSP) were trialled sequentially to determine whether they added relevant literature.

<Insert Figure 1 about here>

Search terms were run through Medline and Psychinfo to access the medical and psychological literature, and through CINAHL (Cumulative Index to Nursing and Allied Health Literature) to access the allied health professions literature. Initial results were subject to search limits:

- *English language only*. It was beyond our scope to commission translations.
- *2003 to current (July 2010) only*. The Mental Health (Care and Treatment) (Scotland) Act 2003 defines the field locally at present, and its year of publication was set as a limitation.

Abstracts were subject to *broad exclusion criteria*, applied sequentially. Articles were retained for further inspection where all criteria were met. Where this could not be determined from the abstract, the article was carried forward to method review:

- *Original research published in a peer reviewed journal*. Editorial or commentary articles, book chapters and unpublished dissertations were excluded.
- *Adult sample*. Research with child or adolescent samples was excluded as their care and post-discharge experience is likely to differ significantly. 'Older' adult samples were included.
- *Psychiatric sample*. Research with patients admitted for physical reasons – even where mental disorder was examined (e.g. depression in cardiac patients) – was excluded.
- *Inpatient sample*. Research in day-patient or supported-tenancy settings was excluded.
- *Pre- and post-discharge measures.* Research not including measures at both time-points was excluded.

Full text of retained articles was obtained, and their 'methods' reviewed with regard to the following *detailed exclusion criteria*, applied sequentially. Articles were retained for further inspection where all criteria were met (NB on inspection 7 articles were found to be commentaries and excluded):

- *Setting*: The focus is the general psychiatric inpatient setting. Research in psychiatric hospitals or units were included. Studies in very specific settings where factors other

than patient presentation may influence discharge - e.g. forensic services — were excluded.

- *Sample*: The focus is adults with psychiatric disorder. Research with samples of patients with specific diagnoses (e.g. schizophrenia) or mixed samples were included. Studies with samples recruited *on the basis of* co-morbid substance use or physical disorder were excluded

- *Measures*: The focus is psychological factors. At least one baseline measure must be psychological. Individual measures of cognitive function, symptom severity and psychosocial functioning were included. Categorisations on the basis of diagnosis or sociodemographic characteristics were excluded.

- *Timing*: The focus is patient state at time of discharge. Baseline measures must be administered at the time of discharge. Studies in which baseline measures were administered at time of admission or at an unspecified time during admission were excluded

- *Analysis*: Statistical analyses should explicitly relate measures at discharge to measures at follow-up. Cross-sectional between-group analyses, or analyses where baseline characteristics were controlled for were excluded.

The 13 publications from which the 16 retained articles were drawn were manually searched, followed by a review of articles citing or cited by included articles using Web of Science and Google Scholar. No further articles were identified. Pertinent study characteristics and findings were extracted and are summarised in Table 1. Ceskova *et al.* (2008) was excluded *post-hoc* when found to be republication of data from an article previously examined (Ceskova *et al.,* 2007).

Articles were evaluated using the Method for Evaluating Research and Guideline Evidence (MERGE; Liddle *et al.,* 1996), a checklist for evaluating studies of risk factors. MERGE provides six criteria against which studies are rated 'a' to 'c' (or 'not adequately described' or 'not applicable') before being awarded an overall rating of A to C. Criteria were operationalised as follows:

1. *Are study participants well-defined in terms of time, place and person?* Fulfilled where; diagnoses were made according to standardised criteria; recruitment was clearly described; basic socio-demographic characteristics were reported.

2. *What percentage of individuals or clusters refused to participate?* Fulfilled where percentage of eligible persons declining to participate was reported to be <20% or between group comparisons demonstrated sample representativeness.

3. *Are outcomes measured in a standard, valid and reliable way*? Fulfilled where; categorical variables (e.g. remitted/not remitted) were appropriately defined; standardised measures have been validated with the relevant population.

4. *Are risk factors and outcomes measured independently (blind) of each other*? Fulfilled where researcher blinding was reported.

5. *Are all important risk factors included in the analysis*? The exploratory nature of the research area made it unfeasible for any study to include all *potential* risk factors. Fulfilled where risk factors of interest (e.g. cognitive function) were assessed by clearly defined criteria or standardised measures previously demonstrated to be valid with the relevant population.

6. *What percentage of individuals or clusters recruited into the study are not included in the analysis?* Fulfilled where; attrition < 20%; attrition <25% and between groups comparisons indicate similarity of completers/non-completers on known measures.

Significant variation in variables and analytic procedures precluded an empirically rigorous approach to data synthesis e.g. meta-analysis. A narrative account of findings is reported.

Results

<Insert Table 1 about here>

Study Characteristics

Studies took place in 11 geographically and culturally diverse countries. The predominant setting was the psychiatric department of a public hospital. Two studies took place in

psycho-geriatric units (Huuhka *et al.,* 2004; Morrow-Howell *et al.,* 2006), one did not report setting (Ucok *et al.,* 2006).

Thirteen studies adopted a prospective follow-up design. Honkonen *et al. (*2007) and Salokangas *et al.* (2007) reported on different aspects of one larger retrospective study. Thirteen studies 'recruited' all eligible admissions or discharges during the study period. Smith *et al. (*2004) recruited participants at the point of discharge, while Ucok *et al.* (2006) reported on a subgroup of participants recruited to a larger trial. The duration of the follow-up period ranged from 12 weeks (Qurashi *et al.,* 2006) to 3 – 7 years (Jager *et al.,* 2003), with a mean of 596 days (S.D. 633 days, median 365 days, mode 365 days).

Eligibility criteria, where reported, varied but typically restricted age and comorbid diagnoses. The most commonly included diagnosis was schizophrenia, either including (Smith *et al.,* 2004; Prince, 2005; Cuesta *et al.,* 2006), or not including schizoaffective disorder (Honkonen *et al.,* 2007; Salokangas *et al.,* 2007). Two specified first episode schizophrenia (Ucok *et al.,* 2006; Ceskova *et al.,* 2007). Three studies took a mixed sample (Hay *et al.,* 2003; Qurashi *et al.,* 2006; Mellesdal *et al.,* 2010) while three examined participants with diagnoses of major depression (Huuhka *et al.,* 2004; Morrow-Howell *et al.,* 2006; Tseng *et al.,* 2006). One study examined participants with a first admission for psychosis (Cougnard *et al.,* 2006) and one with diagnoses of acute and transient psychotic disorder (Jager *et al.,* 2003). All but one study (Morrow-Howell *et al.,* 2006) established diagnoses with reference to standardised criteria.

A total of 6002 participants were assessed, however with wide variation (S.D. = 789.8, range 50 – 2502) the mean sample size (N = 400) is large but not representative. Genders were approximately evenly represented, with males comprising 52.4% of 6002 participants. Again however there was variation between studies, with percentage males ranging from 17.6% (Huuhka *et al.,* 2004) to 100% (Ceskova *et al.,* 2007). Males predominated in studies of schizophrenia/psychosis while females predominated in studies examining depressive disorders. Given between-gender variation in prevalence (e.g. DSM-IV; American Psychiatric Association, 2000) this does not necessarily indicate sampling bias. The mean reported age of participants was 40.8 years (S.D. 16.5, range 21.2 – 76.2). Additional sociodemographic characteristics examined included marital status, educational attainment,

income/employment, race/ethnicity, accommodation, socioeconomic status, social support and forensic history.

The most common analytic approach was to categorise participants at follow-up by outcome variable (e.g. 'remitter' or 'non-remitter'; Ceskova *et al.,* 2007) and conduct between groups analyses (Jager *et al.,* 2003; Qurashi *et al.,* 2006; Ceskova *et al.,* 2007) and/or regression analyses (Prince, 2005; Cougnard *et al.,* 2006; Morrow-Howell *et al.,* 2006; Tseng *et al.,* 2006; Ucok *et al.,* 2006; Honkonen *et al.,* 2007) to determine independent variables associated with outcome. Three studies used regression analyses to examine continuous/dimensional outcome variables (Smith *et al.,* 2004; Cuesta *et al.,* 2006; Salokangas *et al.,* 2007). Two studies (Hay *et al.,* 2003; Cuesta *et al.,* 2006) examined correlations between multiple measures, within and between points of assessment, and three studies (Huuhka *et al.,* 2004; Morrow-Howell *et al.,* 2006; Mellesdal *et al.,* 2010) used survival analyses to examine predictors of time to readmission.

In addition to sociodemographic characteristics (where examined) studies examined a total of 79 independent variables (mean 8.3, S.D. 4.0, range 1 – 15, median 8), with some measures (e.g. Global Assessment of Functioning) appearing in more than one study, and some constructs (e.g. depression) being assessed with more than one measure. Twenty-six psychological variables were examined, falling into four broad categories; psychopathology, insight, cognitive function and global psychosocial functioning.

Study Findings

Psychopathology

Ten studies administered one or more measures of psychopathology. Morrow-Howell *et al.* (2006) assessed older adults with major depression using the Geriatric Depression Scale (GDS; Yesavage *et al.,* 1982) and the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962). Neither was associated with placement at six month follow-up (continuous community stay, psychiatric readmission or nursing home) in bi-variate analyses. Survival analysis indicated that BPRS score at discharge was associated with longer time to readmission, but this did not attain statistical significance ($X2 = 3.41$, $p = .06$). Data was

gathered from multiple sources, but standardised measures were missing for around 20% of participants.

Prince (2005) also used the BPRS plus a measure of depression: the CES-D (Center for Epidemiological Studies – Depression; Radloff, 1977). In participants with schizophrenia or schizoaffective disorder no differences were found in either measure at discharge between those who were or were not adherent to outpatient treatment at three months post-discharge. Non-adherence was clearly defined as discontinuing contact after at least one appointment. However included services varied widely, (e.g. clinics, day hospitals, 'clubhouses' and substance misuse services) and subgroup analyses were not conducted. Qurashi *et al.* (2006), conducting between-group analyses found no difference in discharge scores on the BSI (Beck Scale for Suicidal Ideation; Beck & Steer, 1985) between those who were adherent to medication and those who were not 12 weeks post-discharge.

Smith *et al.* (2004) administered measures of symptomatology, insight and cognitive function to 50 individuals with diagnoses of schizophrenia or schizoaffective disorder at discharge and 6 months follow-up. They found a rating of depression derived from the BPRS at discharge was a significant predictor in a model which explained 59% ($F = 16.59$, $df = 4,39$, $p < 0.001$) of the variance in unawareness of past positive symptoms of psychosis ($B = -0.36$, $p < 0.001$) but was not a significant predictor in models of current positive symptoms or of past or current negative symptoms. Similarly, a rating of formal thought disorder derived from the Scale to Assess Positive Symptoms (SAPS; Andreasen, 1984) predicted unawareness of current positive symptoms ($B = 0.31$, $p = 0.047$) but not past positive or past or current negative symptoms. Sample size was small considering the number and complexity of statistical analyses and though findings were discussed in relation to literature on cognitive processes in schizophrenia clinical significance was not addressed.

Ucok *et al.* (2006) found that participants treated for first episode of schizophrenia who had relapsed at one year follow-up had greater negative symptoms at discharge than those who had not ($z = -2.78$, $p < 0.01$), but that neither positive nor negative symptoms were predictive of GAF (Global Assessment of Functioning; Jones *et al.* 1995) scores or employment. Measures were re-administered monthly; no psychological variable predicted time to relapse.
Jager *et al.* (2003) categorised participants at follow-up by social functioning (poor or good/fair) and relapse (with or without). Between-group analyses found those with poor

social functioning had higher discharge scores on the negative and depressive syndrome scales of the Manual for the Assessment and Documentation in Psychopathology (AMDP; Bobon, 1983, $p = 0.002$ and $p = 0.013$ respectively). Note that very few participants (9 of total 73) showed poor social functioning. Significant differences were not identified with respect to relapse.

Tseng *et al.* (2006) found neither the BDI (Beck Depression Inventory; Beck *et al.,* 1961), the HAM-D (Hamilton Rating Scale for Depression; Hamilton, 1960) nor a remission variable calculated from the HAM-D differed between participants who remained depressed at follow-up and those who recovered. Ceskova *et al.* (2007) compared discharge scores on the PANSS (Positive and Negative Syndrome Scale; Kay *et al.,* 1987) between men who had remitted one year after first admission, and those who had not. They found no significant differences at the total or subscale level. At the item level three significant differences were identified (conceptual disorganisation, abstract thinking and judgement and insight) however, these were in the counterintuitive direction, i.e. remitters exhibited higher symptom levels at discharge ($p < 0.001$). This study performed 102 between group comparisons without reporting adjustment for family-wise error: it is possible that significant differences arose by chance.

Cougnard *et al.* (2006) found that those with persisting symptoms of psychosis at discharge, assessed by clinical judgement and not operationalised, were more than three times more likely to be readmitted (OR 3.3, 95% CI 1.1 - 10.4), $p = 0.04$). However, Huuhka *et al.* (2004) found no differences in discharge scores on the BDI, the MADRS (Montgomery and Asberg Depression Rating Scale; Montgomery & Asberg, 1979) or CGI (Clinical Global Impression Change Scale; Guy, 1976) between older adults who were rehospitalised within one year and those who were not. Nor did these scores predict time to rehospitalisation. Sample size in this study was small, and further reduced by division into treatment groups.

Insight

Cuesta *et al.* (2006) sought correlations between measures of cognitive function and insight, both cross-sectionally and longitudinally. Despite conducting factor analysis to optimise the number of variables, they found no significant correlations between cognition and insight. Nor did regression analysis find baseline cognitive factors to be predictive of change in

insight over the follow-up period. Qurashi *et al.* (2006) however, found insight in a mixed sample, measured by the SAI (Schedule for the Assessment of Insight; Kemp & David, 1997) was higher at discharge in participants who were compliant with medication at follow-up ($p = 0.04$).

Cognitive function

As previously described, Cuesta *et al.* (2006) using multiple measures found no significant correlations between cognition and insight at discharge or follow-up. Smith *et al.* (2004) used the Wisconsin Card Sorting Test (WCST; Heaton, 1981) as a measure of executive functioning in a sample of persons hospitalised with psychotic symptoms. Executive functioning predicted of unawareness of past negative symptoms ($B = 0.41$, $p = 0.015$), though the model only predicted 21% of the variance ($F = 3.30$, $df = 4,31$, $p = 0.023$). The study did not control for current or premorbid cognitive functioning, and acknowledged the limitation in generalizability arising from the use of a single measure of cognition.

The Mini Mental State Evaluation (MMSE; Folstein *et al.,* 1975) was used by two studies, without significant findings. Huuhka *et al*. (2004) found no differences in mental state at discharge between depressed older adults who were rehospitalised within one year and those who were not. Morrow-Howell *et al.* (2006) observed a trend towards significance ($p = 0.07$) in bi-variate analyses with their three category disposition variable; patients with lower scores were more likely to require nursing home placement. When carried forward into regression analysis, this variable did not attain significance as a predictor.

Global psychosocial functioning

Broad measures of psychosocial functioning were administered by nine studies, with variable findings. The GAF was found by Morrow-Howell *et al.* (2006), to predict nursing home placement of depressed older adults (coefficient -0.0785, $z = -1.99$. $p = 0.05$). This study also evaluated psychosocial problems using a count of problems on the DSM-IV Axis 4 (APA, 2000). There was no relationship between this variable and placement at follow-up.

Mellesdal *et al.* (2010) found the split version of the GAF (GAF-S; Karterud *et al.* 1998) to be predictive of time to readmission in a mixed sample. On closer examination the effect was

nonlinear and significant only where scores were lower. Employment at 1 year follow-up was predicted by the GAF at discharge (B = -0.08, wald = 3.51, df = 1, p = 0.05) in the Ucock *et al.* (2006) study of first-episode patients with schizophrenia. GAF did not however differentiate relapsed participants from those without relapse in the same study.

Hay *et al.* (2003) administered three broad measures of functioning, the GAF, the GARF (Global Assessment of Relational Functioning; APA, 2000) and the SOFAS (Social and Occupational Functioning Assessment Scale; APA, 2000) to a mixed sample of participants at discharge and two year follow-up. They sought correlations between the measures at each point and across time. Only the SOFAS at discharge was correlated with any measure at outcome (SOFAS r = 0.38, p < 0.01, GAF r = 0.39, p < 0.01).

Use of the Global Assessment Scale (GAS; Endicott *et al.* 1976) also produced variable results. Honkonen *et al.* (2007) in their large study of patients with schizophrenia discharged in three cohorts over an eight year period, found significant differences in GAS score at discharge between those who were employed and those who were not at three year follow-up (F = 26.605, p < 0.001). This did not remain a significant predictor in logistic regression. Salokangas *et al.* (2007) examined a different dataset from the same study. In univariate ANOVA participants' number of problems in social role behaviour at follow-up varied with GAS score at discharge (p < 0.001). In this case though, the GAS remained a significant predictor when tested in a general linear ANOVA (95% CI -2.387 - -1.174, p = 0.001). The sample size was large in both studies, but due to their retrospective nature, detailed information about – for example – symptom severity could not be examined or controlled for. In between group analyses no significant differences in GAS at discharge were identified between participants categorised by relapse status or by social functioning at 3-7 years (Jager *et al.,* 2003) or by adherence to outpatient treatment at 12 weeks (Prince, 2005).

Study Appraisal

<Insert Table 2 about here>

Overall, seven studies were awarded a rating of 'A', and eight a rating of 'B1'. Populations (criterion one) were clearly described and inclusion/exclusion criteria (where applicable) adequately reported. All but one study (Morrow-Howell *et al.,* 2006) specified use of

standardised diagnostic criteria (ICD-10, 5 studies; DSM-III-R, 3 studies; DSM-IV, 6 studies) and were rated 'a'.

The recruitment strategy of including all eligible admissions or discharges rendered criterion two inapplicable, as there is an implication (though not usually a clear statement) that all eligible persons are included in baseline analyses. These were assigned a rating of 'n/a'. Four studies did report non-participation rates, observing only minor statistically significant differences between participants and non-participants. These were rated 'b1'. The two studies which conducted open recruitment (Smith *et al.,* 2004; Ucok *et al.,* 2006) did not report on non-participants, while Ceskova *et al. (*2007) did not account for reporting on only 93 of 160 database registrants. These studies were rated '?'

Outcome measures (criterion three) were diverse, but pertinent to the field of study. Outcomes were objectively verifiable (e.g. readmission,) or categories/measures (e.g. relapse) were clearly defined. All studies were rated 'a'. Blinding of researchers (criterion four) was less consistently evidenced. Eleven studies made no reference to blinding, and were rated '?'. Three studies (Hay *et al.,* 2003; Cougnard *et al.,* 2006; Cuesta *et al.,* 2006) reported blinding, and were rated 'a', while one (Qurashi *et al.,* 2006) noted that researchers were *not* blind, but that multiple raters were consulted, and was rated 'b1'.

As previously noted, the exploratory subject area precludes exhaustive inclusion of potential predictors, and criterion five was deemed met where predictors were clearly operationalised and appropriately measured. With this amendment, 13 studies were rated 'a'. Cougnard *et al.* (2006) was rated 'b1' for use of 'clinical judgement' in ascertaining presence of symptoms, as was Hay *et al.* (2003) which aimed to establish the validity of measures which are therefore not yet demonstrated valid. All studies were very – though not exclusively - reliant on self-report measures, though three (Cougnard *et al.,* 2006; Morrow-Howell *et al.,* 2006; Salokangas *et al.,* 2007) gathered supplementary data from carers.

The final criterion, loss to follow-up, showed greatest variability. Two studies (Smith *et al.,* 2004; Ceskova *et al.,* 2007) provided insufficient information for rating. The remainder reported attrition ranging from 0.23% (Cougnard *et al.,* 2006) to 38.1% (Hay *et al.,* 2003). Seven studies conducted between group analyses between completers and lost-too-follow-up, with three (Hay *et al.,* 2003; Cuesta *et al.,* 2006; Honkonen *et al.,* 2007) observing significant

differences. Seven studies were rated 'a', three were rated 'b1' where attrition exceeded 20% without significant between-group differences and three were rated 'b2' where attrition exceeded 20% with significant between-group differences.

Discussion

Conclusions

Studies varied widely in sample population, measures, duration of follow-up period and analytic approach. No two were directly comparable. Four studies found no relationship at all between psychological measures at discharge and outcomes. Although 11 did find statistically significant links, study characteristics call into question the clinical significance of the findings. Two studies (Hay *et al*., 2003; Cuesta *et al*., 2006) sought only correlations between measures across time, and did not explicitly relate these to 'real-life' outcomes. Several studies found that though psychological measures at discharge showed between group differences, these did not attain independent predictor status following regression analyses, and regression models themselves often explained only limited variance. Though lack of directly comparable studies also prevents any direct contradiction between findings, there was a general lack of coherence both between studies; for example psychosocial functioning was related to employment in one study but not another (Ucok *et al.,* 2006; Honkonen *et al.,* 2007); and within studies – for example the finding by Smith et al. (2004) that no predictor was associated with more than one of the four measures of insight.

It is impossible to conclude on the basis of this review that there is consistent evidence that psychological measures at discharge are predictive of outcomes following inpatient psychiatric care. There is no indication that the inclusion of such measures in risk assessment algorithms will incrementally add predictive power sufficient to outweigh the difficulties previously described in incorporating them.

Limitations of the studies

Though studies were rated highly according to MERGE, study design may have led to the lack of consistent findings. More than one study described itself as 'naturalistic': making use of measures administered in routine practice. This may improve the generalisability of

findings. It appears though that opportunistic inclusion of available data rather than careful assessment of constructs *a priori* determined to be of theoretical interest, has led in some cases to large numbers of loosely and atheoretically linked variables. These may 'muddy' the analytic waters and make less likely the detection of specific effects. They have certainly made interpretation, synthesis and reporting of findings more challenging.

Although the rating of studies acknowledged the unfeasibility of comprehensively assessing all possible predictors, more comprehensive assessment of specific psychological variables rather than use of general psychopathology or global functioning measures may have increased the likelihood of identifying psychological predictors.

Limitations of the review

The process of review, in particular defining of inclusion criteria, may have introduced bias to the findings. This might result from specific criteria being either too restrictive, or too permissive. Considering the former, limiting the search to English language publications risks excluding politically and culturally diverse viewpoints and restricting generalisability of findings, though in his case the majority of reviewed papers were from non-English speaking nations. The time limitation poses a more likely threat. With 2003-10 representing a relatively brief and recent interval, it is possible that prior publications evidencing consistent links have been excluded. Notably though, no reviewed paper made reference to any substantial evidence base for psychological predictors.

Specifying the timing of the administration of psychological measures which may be subject to change during admission (indeed the five studies which compared admission-discharge data – Huuhka *et al.,* 2004; Morrow-Howell *et al.,* 2006; Tseng *et al.,* 2006; Ucok *et al.,* 2006 and Ceskova *et al.,* 2007– did observe changes) was a strategic decision. Point of discharge was selected as offering the most recent information pre-follow-up. This led to the exclusion of many studies administering measures at admission and, while there are few theoretical or practical reasons to presume that these might prove more promising predictors, this might reasonably be the subject of a further review.

The exploratory nature of the review led to the deliberately broad interpretation of 'psychological' predictors and 'outcomes'. The wide variation in measures and methods is

undoubtedly a result of this decision. More highly specifying either predictors or outcomes of interest, while reducing the number of eligible studies (perhaps to be compensated for by a longer search period) would render findings more easily assimilated. However, since even within this review studies addressing ostensibly the same concepts, for example psychosocial functioning and employment (Ucok *et al.,* 2006; Honkonen *et al.,* 2007), have reached opposing conclusions, it does not logically follow that a more specific review will find more consistent outcomes.

Although designed as a 'quick' means of assessing non-RCT studies (Liddle *et al.,* 1996) there are criteria absent from the MERGE checklist which may have been pertinent. For example, no consideration is made of the adequacy of the follow-up period or of the appropriate use of statistics. While it complicates the tool to include them, either one may invalidate the conclusions of an otherwise 'A' rated study. It is also possible that interpretation of the criterion regarding selection of risk factor/predictor variables has been erroneous and artificially elevated study ratings.

Implications for research

This review is subject to methodological limitations and these should be addressed in any future reviews. Consistent with the MERGE approach however, one must consider whether addressing these issues would substantially alter the findings. Given that the principal conclusions concern inconsistency of methods and findings, it seems addressing these issues in the original research, will be the more effective step in furthering understanding of psychological predictors of outcome following discharge.

Future research should proceed from a specific hypothesis about a relationship between a psychological construct and an outcome. Predictors and outcomes should be clinically relevant. Measures should be carefully selected on the basis of validity, and not availability or ease of completion. Follow-up period should be determined theoretically, not by convenience. Possible confounding variables, identified *a priori*, should be assessed and where appropriate controlled for. Analyses should address one predictor or one outcome at a time.

These adjustments would increase the probability of identifying any predictive relationships. There is though the possibility that psychological factors are simply too variable over time, too imprecisely measured or too closely associated with other more robustly measured variables to function as independent predictors of outcomes over long periods of time. In this case tracking the relative input of predictors longitudinally, or searching for mediating/moderating effects may be fruitful avenues of future research.

Clinical implications

The findings of this review do not support the administration of measures of psychological state at discharge from inpatient psychiatric care for the purposes of predicting long term outcomes. This does not invalidate the use of such measures for assessment of presenting problems or support needs in the short term.

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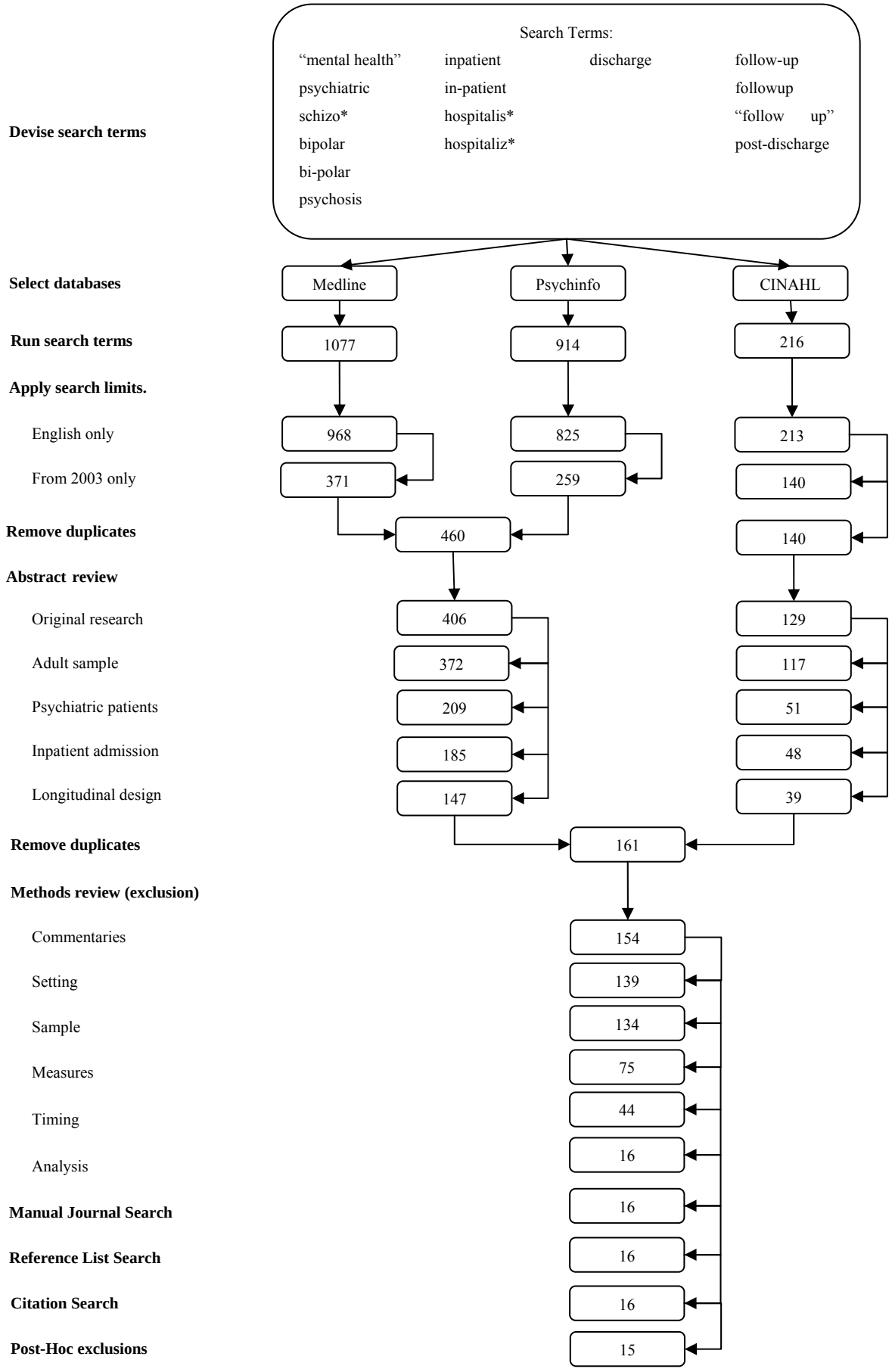


Figure 1: Visual representation of the literature search process.

Table 1: Study characteristics and findings.

reference/setting/design/ recruitment/follow-up period	included diagnoses/means established	included diagnoses/means established	sample characteristics	variables	analysis	relevant findings*
Ceskova et al. (2007) Czech Republic, University Hospital. Prospective follow-up study. Hospital maintained database of longitudinal observations of first admitted patients. 1 year.	Schizophrenia (first episode). ICD-10 diagnostic criteria; assessment by 2 pssychiatrists.	Male. First hospitalisation. Gave written consent. Completed 1 year follow-up. Not reported.	N = 93. Male: 100%. Mean age: 23 years. Mean duration of illness: 0.77 years. ADD antipsychotics (discharge): 228mg. ADD antipsychotics (follow-up): 127mg.	- *Positive and Negative Syndrome Scale (PANSS)* [a,d,f]	Participants categorised at follow-up as 'remitters' (score ≤ 3 on PANSS items P1, P2, P3, G5, G9, N1, N4 and N6) or 'non-remitters'. Between groups analyses (*Mann-Whitney U, Wilcoxon matched pairs, Chi square*) conducted for: - Relative decrease in PANSS scores (subscales and total) admission to discharge. - Relative decrease in PANSS scores (subscales and total) discharge to follow-up. - PANSS scores (individual items, subscales and total) at admission, at discharge and at follow-up.	PANSS total scale score at discharge: non-remitters = remitters. PANSS negative subscale score at discharge: non-remitters = remitters. PANSS positive subscale score at discharge: non-remitters = remitters. Item P2 'conceptual disorganisation' at discharge: non-remitters < remitters ($p < 0.001$). Item N5 'abstract thinking' at discharge: non-remitters < remitters ($p < 0.001$). Item G12 'judgement and insight' at discharge: non-remitters < remitters ($p < 0.001$).
Cougnard et al. (2006) France, Public Hospital. Prospective follow-up study. Consecutive eligible admissions. 2 years.	First admission psychosis; categorised as 'schizophrenia broadly defined' (N = 53, 61.6%) or 'psychotic mood disorder' (N = 33, 38.4%). ICD-10 diagnostic criteria; ward psychiatrist.	Gave informed consent. < 50 years old. Fluent in French. No previous psychiatric hospitalisation. ≥ 1 overt psychotic symptom (as defined by WHO). Not reported.	N = 86. Male: 55 (63.9%) female: 31 (36.1%). Mean age: 27.8 ± 6.9 years. Single: 72 (83.7%). Unemployed: 43 (50%).	Number and type of helping contacts: 'psychiatrist', 'GP' or 'other' [d,f] Time to first psychotropic treatment: '>26 weeks' or '<26 weeks'. Time to first hospitalisation: '>48 weeks' or '<48 weeks'. Type of admission: 'voluntary' or 'compulsory'. Duration of admission: '>5 weeks' or '<5 weeks'. Diagnosis. - *Clinical judgement.* Percentage time unemployed during follow-up period. Ever psychotic during follow-up period: 'yes' or 'no'. Substance use during follow-up period: 'yes' or 'no'. Medication adherence: 'poor' or 'good'. Readmissions during follow-up period: 'at least one' or 'none'.	Participants categorised at follow-up as 'at least one readmission' or 'no readmission'. *Logistic regression* (adjusted for age, gender and diagnosis) to determine: - Baseline characteristics independently predicting readmission. - Social and clinical outcomes associated with readmission.	Persisting psychotic symptoms at discharge predicts readmission OR 3.3 (95% CI 1.1 - 10.4), $p = 0.04$).
Cuesta et al. (2006) Spain, Hospital Psychiatric Unit. Prospective follow-up study. Consecutive eligible admissions. > 6 months.	Schizophrenia (N = 37), affective disorder with psychotic symptoms (N = 27), or schizoaffective disorder (N = 11). DSM-IV diagnositic criteria.	Presenting at least one psychotic symptom (by Comprehensive Assessment Schedule History). Giving informed consent. Organic central nervous disorder. Drug or alcohol abuse in past year. Learning disability.	N = 75; 56 'completers' 19 'lost to follow-up'. Age: 33.71 ± 9.0 years, 35.00 ± 11.40 years. Education: 10.73 ± 3.24 years, 9.21 ± 1.96 years. N of episodes: 5.16 ± 4.74, 6.00 ± 7.08. Males: 62.5%, 64.9%. Single: 73.2%, 81.1%.	- *Scale to assess Unawareness of Mental Disorder (SUMD)* [d,f] - *Insight and Treatment Attitudes Questionnaire (ITAQ)* [d,f] - Insight items from *Manual for the Assessment and Documentation in Psychopathology (AMDP)*; lack of feeling ill, lack of insight, uncooperativeness [d,f] - *WAIS* Information subtest [d,f] - *WMS* logical memory subtest [d,f] - animals named in one minute [d,f] - Trail making test [d,f] - *Stroop* color word test [d,f] - *Wisconsin Card Sorting Test* [d,f]	Correlation (*Pearson's*) between cognitive and insight measures (baseline and follow-up). *Principal component factor analysis* (N = 2, insight and cognitive measures) to reduce variable numbers. *Multiple regression* to determine whether baseline cognitive variables predict insight at follow-up.	"insight dimensions and cognitive performance were not found to be significantly associated at cross sectional and longitudinal assessments. In addition baseline cognitive performance did not explain changes in insight dimensions at follow-up." (p.1)
Hay et al. (2003) Australia, Metropolitan Teaching Hospital. Prospective follow-up study. Consecutive psychiatric admissions. 2 years.	Mixed sample; schizophrenia or other nonorganic psychotic disorder (N = 28, 29%); mood disorder (N = 34, 35%); organic mental disorder (N = 11, 11%); other disorder e.g. adjustment disorder (N = 22, 23%). DSM-IV diagnostic criteria; admitting clinician.	Not reported. Not reported.	N = 97. Female: 63 (65%). Caucasian: 92 (95%). Mean age: 39.9 ± 16 years. Widowed/divorced/never married: 81 (79%).	Sociodemographics Length of stay Diagnosis Ratings of DSM-IV axes - *Global Assessment of Functioning (GAF)* [a,d,f] - *Social and Occupational Functioning Assessment Scale (SOFAS)* [a,d,f] - *Global Assessment of Relational Functioning (GARF)* [a,d,f] - *Client Satisfaction Questionnaire* [f] - *Health of the Nation Outcomes Scale (HoNOS)* [f] - *Symptom Checklist* (SC-53) [f] - *Social Adjustment Scale Self-Report - Modified (SAS-M)* [f] - *Social Functioning Scale (SF-36)* [f]	Correlations (*Spearman's*) examined between: - All measures (at subscale level) at admission. - All measures (at subscale level) at discharge. - All measures (at subscale level) at follow-up. - All measures (at subscale level) between timepoints.	only the SOFAS scores at discharge correlated with SOFAS ($r = 0.38$, $p < 0.01$), GAF ($r = 0.39$, $p < 0.01$) and HoNOS ($r = -0.43$, $p < 0.01$) scores at follow-up.

Table 1(cont) : Study characteristics and findings.

reference/setting/design/ recruitment/follow-up period	included diagnoses/means established	included diagnoses/means established	sample characteristics	variables	analysis	relevant findings*
Honkonen et al. (2007) Finland, Psychiatric Hospitals. Retrospective follow-up study. Consecutive eligible discharges from psychiatric hospitals in years 1986, 1990 and 1994 until sample for each year reached 30 per 100,000 of the general population. 3 years.	Schizophrenia: disorganised (15.4%), catatonic (3.9%), paranoid (33.9%), residual (8.5%) and undifferentiated 38.2%). DSM-III-R diagnostic criteria; researcher-physicians review of case records.	15-64 years old. Schizoaffective and schizophreniform disorders.	N = 2166. Male: 1189 female: 979. Mean age (at discharge): 39.2 ± 10.4 years. Marital: single 70.3% ever married 29.7%. Duration of illness (at discharge): 14.6 ± 9.6 years. Socioeconomic status: self-employed 4.8%, white collar 17.4%, blue collar 55.9%, unemployed 21.6%. Receipt of disability pension: yes 84.2%, no 15.7%.	Sociodemographics. Diagnosis. Year of discharge. Medication dosage at discharge. Planned use of vocational rehabilitation. Number of contacts during follow-up period. Number of inpatient days during follow-up period. - *Global Assessment Scale (GAS)* [d] Employment status: 'competitively employed' or 'non-employed'	Participants categorised at follow-up as 'employed' or 'not employed'. Between groups analysis (*chi2, one way Anova*) conducted on demographic and admission and discharge variables. *Binary logistic regression* (adjusted for sociodemographic and clinical characteristics) with respect to employment status. *Logistic regression* (N = 2, employment, non-employment) to determine sociodemographic and baseline predictors.	GAS score at discharge: employed > non-employed (F = 26.605, p < 0.001). Binary logistic regression: GAS at discharge OR 1.37 (95% CI 0.82 - 2.31 n.s.). GAS 'significant predictor of non-competitive employment' (figures not reported).
Huuhka et al. (2004) Finland, Psychogeriatric Department, University Hospital. Prospective follow-up study. Consecutive eligible admissions. 1 year.	Major depressive disorder (including those with psychotic features). DSM-IV diagnostic criteria.	Not reported. Dementia. Alcohol or other substance misuse. Depression due to organic factors.	N = 51; 30 ECT group, 21 ADT group. Female: 22 (73.3%), 20 (95.2%). Age: 69.6 ± 6.2 years, 73.1 ± 7.5 years. Married: 16 (53.3%), 6 (28.6%). Living alone: 10 (33.3%), 14 (67.0%). Own home: 28 (93.3%), 17 (80.9%). Education < 8years: 2 (6.7%), 4 (19.1%).	Sociodemographics. Somatic illnesses. Clinical variables; age at onset, duration, prior admissions. - *Montgomery and Asberg Depression Rating Scale (MADRS)* [a,d,f] - *Beck Depression Inventory (BDI)* [a,d,f] - *Clinical Global Impression Change Scale (CGI)* [a,d,f] - *Mini Mental State Examination Scale (MMSE)* [a,d,f] - *Activities of Daily Living (ADL)* [a,d,f] - *Instrumental Activity of Daily Living (IADL)* [a,d,f] - *Quality of Life Enjoyment and Satisfaction Questionnaire (Q-Les-Q)* [a,d,f] - *Measurement of life Satisfaction Scale (LSS-A)* [a,d,f] Rate of rehospitalisation.	Between (treatment) group analyses (*chi2, t-test*) on baseline data. *Linear regression* to explain change in MADRS score at discharge. Participants categorised as 're-hospitalised' or 'not rehospitalised' Between (rehopsitalised/not' groups analysis of baseline data. Survival analysis (*Kaplan-Meier*) to test between (treatment) group differences in rehospitalisation. *Cox regression* to determine predictors of rehospitalisation.	"no differences were found even within the ECT or the ADT group in any demographic or basic clinical assessments such as depression rating scores (even at admission or discharge) between the patients who were rehopsitalised and those who were not." p.183
Jager et al. (2003) Germany, University Hospital. Prospective follow-up study. Consecutive eligible admissions.	Acute and transient psychotic disorder (F23). ICD-10 diagnostic criteria; resident psychiatrists.	First hospitalisation. Not reported.	N = 94. Male: 49 (52%) female: 45 (48%). Mean age at first hospitalisation: 33.1 ± 10.6 years.	- *Manual for the Assessment and Documentation in Psychopathology (AMDP)* [a,d] - *Global Assessment Scale (GAS)* [a,d] - *Strauss-Carpenter Scale* Relapse during follow-up period. Rehospitalisation during follow-up period. - *Short Disability Assessment Schedule (DAS-S)* [f]	Participants categorised at follow-up as 'with relapse' or 'without relapse', and 'poor' or 'good/fair' social functioning. Between group analyses (*Mann-Whitney U, chi2*) conducted on admission and discharge variables.	AMDP negative syndrome at discharge: 'poor' > 'good/fair' social functioning, p = 0.002. AMDP depressive syndrome at discharge: 'poor' > 'good/fair' social functioning, p = 0.013.
Mellesdal et al. (2010) Norway, University Hospital. Norway, University Hospital. Consecutive admissions. Mean: 562 days (S.D. 102.7)	Mixed sample; given one primary diagnosis and up to two secondary diagnoses. ICD-10 diagnostic criteria; psychiatrists, registrars or psychologists.	Not reported. Not reported.	N = 1156. Male: 631 (55%). Mean age: 41.9 ± 16.6 years. Income: employed/student/ retired 324 (30%) sickness/disability/ unemloyment 755 (70%). Living: co-habiting: 462 (42%) alone: 480 (43%) staffed residence: 85 (8%) homeless/prison: 83 (8%). Education: primary school: 531 (48%) beyond primary school: 569 (52%).	Sociodemographics. Admission due to suicide risk: 'ideation', 'behaviour', 'attempt', 'none'. Diagnosis. Pre-admission contact: 'admission > 1 year ago', 'admission < 1 year ago', 'outpatient', 'none'. Length of index admission. - *Global Assessment of Functioning - Split Version (GAF-S)* [d] Time to readmission. Time to readmission due to suicide risk.	*Cox regression analyses* (univariate and mutlivariate) to determine predictors of: - Time to readmission. - Time to readmission due to suicide risk. *Poisson regression* to determine predictors of rate of readmission.	GAF-S at discharge predicts time to readmission (p = 0.021) but effect found to be non-linear; flexible non-linear modelling (p = 0.418) reveals significance only at low GAF-S values.

Table 1(cont) : Study characteristics and findings.

reference/setting/design/ recruitment/follow-up period	included diagnoses/means established	included diagnoses/means established	sample characteristics	variables	analysis	relevant findings*
Morrow-Howell et al. (2006) USA, Geropsychiatric Unit, Urban Teaching Hospital. Prospective follow-up study. Consecutive eligible admissions. 6 months.	All subtypes of major depression. Clinical assessment of medical director.	≥ 60 years old. Hospitalised for depression. Discharged to a community setting. Giving informed consent. Bi-polar depression; manic phase. Cognitive impairment precluding reliable information.	N = 199. Mean age: 76.2 ± 7.124 years. Male: 30.2%. Race: caucasian 85.9% African American 14.1 %. Education (6 ordinal categories): mean 3.2 ± 1.636. Income (16 ordinal categories): mean 10.4 ± 3.437. Married: 41.7%. Social support (6 ordinal categories): mean 3.0 ± 1.185. Living alone: 29.6%. Rural: 19.6%.	Sociodemographics. Late onset of depression: 'yes' or 'no'. Prior episodes of depression: 'yes' or 'no'. Number of prior admissions. Psychotic features of depression: 'yes' or 'no'. - *Brief Psychiatric Rating Scale (BPRS)* [a,d] - *Global Assessment of Functioning (GAF)* [a,d] - *Geriatric Depression Scale (GDS)* [a,d] - *Mini Mental State Examination Scale (MMSE)* [a,d] - *Chronic Illness Rating Scale – Geriatric* [d] - *OARS Activities of Daily Living* [d] - N of problems on DSM Axis 4 [d] For each day post-discharge: 'community', 'hospital - medical', 'hospital - psychiatric', 'nursing home', 'dead'.	Participants categorised at follow-up as 'continuous community', 'psychiatric readmission' or 'nursing home' disposition. *Bivariate associations* (unspecified) of each independent variable with 3-category disposition variable. *Multinomial logistic regress*ion with 6 variables significantly associated; GAF [d], MMSEd, Functioning [d], change in GDS, ECT, post-acute service use. *Cox regression* to determine predictors of time to psychiatric readmission.	Bivariate associations: BPRS at discharge n.s. GDS at discharge n.s. GAF at discharge F = 4.72, p = 0.01. MMSE at discharge F = 2.76, p = 0.07. Psychosocial problems n.s. Multinomial regression. No variable predicts readmission. GAF at discharge predicts nursing home placement (coefficient -0.0785, z = -1.99. p = 0.05).
Prince (2005) USA, General Hospitals. Prospective follow-up study. Consecutive eligible discharges. 3 months.	a) schizophrenia or b) schizoaffective disorder. (a) DSM-III-R or (b) DSM-IV diagnostic criteria; trained research assistant.	English speaking. Eligible for Medicaid. 17 - 65 years old. Severe and disabling medical condition. Inpatient stay > 120 days. Discharged against medical advice. Transferred to another inpatient facility.	N = 264. Age: 18-30 N = 76, 31-40 N = 99, 40+ N = 89. Sex: 161 male, 103 female. Race: 148 black, 110 white, 5 other. Marital: 187 never married, 51 divorced/separated, 14 married, 5 widowed. Education: 118 <12th grade, 82 12th grade, 49 some college, 15 degree or more. Location: 165 private home, 65 congregate, 34 other. Employment: 103 past year, 131 not in past year. Arrested (lifetime): 127 yes, 137 no. Jailed (lifetime): 64 yes, 200 no. Homeless in past 3 months: 29 yes, 235 no.	Sociodemographics. Compliant with medication at follow-up: 'yes' or 'no'. History of DSM-III-R drug abuse: 'yes' or 'no'. History of DSM-III-R alcohol abuse: 'yes' or 'no'. Index hospitalisation: 'voluntary' or 'involuntary'. Dissatisfied with outpatient care: 'yes' or 'no'. Attended inpatient substance abuse group: 'yes' or 'no'. Attended other inpatient substance abuse service: 'yes' or 'no'. Received mental health service in 2 weeks prior to admission: 'yes' or 'no'. - *Brief Psychiatric Rating Scale (BPRS)* [d,f] - *Center for Epidemiological Studies - Depression (CES-D)* [d,f] - *Global Assessment of Functioning (GAS)* [d,f] Adherence to outpatient programmes.	Participants categorised at follow-up as 'adherent' or 'non-adherent' (discontinuing after keeping ≥ 1 appointment) to outpatient treatment Between group analyses (*chi2, t-tests*) conducted to determine risk factors for subsequent analyses. Significant variables entered into *logistic regression analyses* controlling for age, gender and race.	GAS at discharge: adherent = non-adherent t(258) = 0.45, p = 0.65. CES-D at discharge: adherent = non-adherent t(262) = 1.14, p = 0.25. BPRS at discharge: adherent = non-adherent t(245) = 0.23, p = 0.82.
Qurashi, Kapur & Appleby (2006) UK, Urban Psychiatric Hospital. Prospective follow-up study. Consecutive eligible discharges. 12 weeks.	Mixed sample; schizophrenia (including schizoaffective disorder) N=24, affective disorders N=28, disorders due to psychoactive use N=8, disorders of adult personality N=4, and other N=5. ICD-10 diagnostic criteria.	18 - 65 years old. Discharged without medication. Significant learning difficulties. Deafness. Non-English speaking. Residence outside hospital catchment area. Admission duration < 48 hours.	N = 69. Male: 39 (57%) female: 30 (43%). Mean age: 36 ± 10.5 years.	- *Beck Scale for Suicidal Ideation (BSI)* [d,f] - *Schedule for the Assessment of Insight (SAI)* [d,f] Compliance with medication: 'compliant' or 'noncompliant'. Occurrence of suicidal behaviour: 'yes' or 'no'.	Participants categorised at follow-up as 'compliant' or 'non-compliant'. Between groups analyses (chi2, Mann-Whitney U) on discharge and change scores.	BSI at discharge compliant = non-compliant, p = 0.58. SAI at discharge compliant > non-compliant, p = 0.04.
Salokangas, Honkonen & Stengard (2007) Finland, Psychiatric Hospitals. Retrospective follow-up study. Consecutive discharges from psychiatric hospitals in years 1986, 1990 and 1994 until sample for each year reached 30 per 100,000 of the general population. 3 years.	Disorganised, catatonic, paranoid, residual and undifferentiated schizophrenia. DSM-III-R diagnostic criteria; researcher-physicians review of case records.	15 - 64 years old. Schizoaffective and schizophreniform disorders.	N = 2502. Male: 54% female: 46%. Age: 15-24 7.8%, 25-34 26.7%, 35-44 34.4%, 45-54 21.3&, 55-64 9.8%. Marital: single 69.9%, married 13.0%, divorced/separated 15.2%, widowed 1.8%. Education (years): <8 36.7%, 9-12 45%, 13+ 18.3%.	Sociodemographics. Diagnosis. Physical illness: 'no', 'mild', 'severe'. Ability to work: 'able' or 'not able'. - *Global Assessment of Functioning*) [d,f] Number of neuroleptics: 0, 1, 2, 3+. Dose of neuroleptics Psychosedatives: 'yes' or 'no'. Antidepressants: 'yes' or 'no'. Age at first admission (y): 10-19, 20-29, 30+. Illness duration (y): -4, 5-9, 10-19, 20+. Previous hospital days: 0-60, 60-180, 181-365, 366+. - *MRC Practices Profile* (modified) [f]	Social role behaviour (SRB) means calculated. Univariate ANOVA of SRB by all independent variables. General linear ANOVA to determine predictors of SRB (males, females, total sample).	Univariate ANOVA. GAS at discharge associated with problems in SRB, p < 0.001. General linear ANOVA. GAS at discharge associated with problems in SRB, 95% CI -2.387 - -1.174, p 0.001.

Table 1(cont) : Study characteristics and findings.

reference/setting/design/ recruitment/follow-up period	included diagnoses/means established	included diagnoses/means established	sample characteristics	variables	analysis	relevant findings*
Smith et al. (2004) USA, Acute Inpatient Unit. Prospective follow-up study. Participants recruited on admission to an outpatient program. 6 months.	Schizophrenia (N = 31, 62%) , schizoaffective disorder (N = 19, 38%). DSM-IV diagnostic criteria; SCID.	18 - 50 years old. Hospitalised for treatment of acute psychotic exacerbation. Comorbid diagnosis of substance dependence. Estimated IQ < 70. History of serious traumatic brain injury.	N = 50. Male: 31 (62%). Caucasian: 84% African American 14% Asian: 2%. Mean age: 37 ± 9.5 years. Mean age of onset: 18 ± 7.7 years.	- *Scale for the Assessment of Positive Symptoms (SAPS)* [d,f] - *Scale for the Assessment of Negative Symptoms (SANS)* [d,f] - *Brief Psychiatric Rating Scale (BPRS)* [d,f] - *Wisconsin Card Sorting Test* (% perseverative errors) [d,f] - *Scale for the Assessment of Unawareness of Mental Disorder (SUMD)* [d,f]	*Linear regression* conducted for 4 SUMD follow-up ratings; current positive, current negative, past positive, past negative. - Four baseline variables included; formal thought disorder (from SAPS), depression (from BPRS), executive functioning, corresponding SUMD rating.	Unawareness of current +ve symptoms, F = 4.30, df = 4,32, p = 0.007 (27% of variance). - Formal thought disorder (B = 0.31, p = 0.047). Unawareness of current - ve symptoms, n.s. Unawareness of past positive symptoms, F = 16.59, df = 4,39, p < 0.001 (59% of variance). - Baseline unawareness (B = 0.76, p < 0.001). - Depression (B = -0.36, p = 0.001). Unawareness of past negative symptoms, F = 3.30, df = 4,31, p = 0.023 (21% of variance). - WCST scores (B = 0.41, p = 0.015).
Tseng et al. (2006) Taiwan, Psychosomatic Ward, University Hospital. Prospective follow-up study. Consecutive eligible admissions. Originally recruited as a pre-test outcome group in a clinical pathway for depressed inpatients. 1 year.	Major depressive disorder without psychotic features. DSM-IV diagnostic criteria.	Not reported. Not reported.	N = 67. Female: 48 (71.9%). Mean age at admission: 49.2 ± 15.4 years. Socioeconomic status: 31% upper, 42% middle. Mean duration of episode: 6.0 ± 8.7 months.	Age at onset of depression. Family history of psychiatric illness: 'yes' or 'no'. Comorbid physical illness: 'yes' or 'no'. Previous hospitalisations: 0, 1, 2+. Suicide attempt at index episode. Duration of index episode. Length of stay. Treatment with anticpsychotic. Treatment with ECT. - *Beck Depression Inventory (BDI)* [a,d] - *Hamilton Rating Scale for Depression (HAM-D)* [a,d] Remission status at discharge (HAM-D score ≤ 7). - *Global Assessment of Functioning (GAF)* [a,d] - *Maudsley Personality Inventory (MPI)* [a] - *Family APGAR* [a]	Participants categorised at follow-up as 'depressed' or 'recovered' (DSM-IV diagnosis free for 8 weeks). Between groups analyses (*chi2, t-tests*) conducted on admission variables and remission status. Significant variables entered *into multivariate logistic regression.*	Remission status at discharge: depressed = recovered (values not reported). Individual scale scores at discharge not reported.
Ucok et al. (2006) Turkey, setting not reported. Prospective follow-up study. Recruited to an ongoing larger study; First Episode Schizophrenia Follow-Up Project. 1 year.	Schizophrenia (first episode). DSM-IV diagnostic criteria; SCID.	In remission at point of discharge. 15 - 45 years old. Past diagnosis of non-affective possible psychosis. Previous anti-psychotic treatment or inpatient care. Any organic disorder known to cause psychosis. Alcohol or drug abuse.	N = 74. Mean age: 21.2 ± 4.9 years. Male: 51.3% female: 48.7%. Education (years): 10.9 ± 3.1. Employment status (at follow-up): 47.5% employed.	Sociodemographics. Age at onset. Duration of untreated psychosis (months). - *Brief Psychiatric Rating Scale (BPRS)* [d,f] - *Scale for the Assessment of Positive Symptoms (SAPS)* [d,f] - *Scale for the Assessment of Negative Symptoms (SANS)* [d,f] - *Premorbid Adjustment Scale (PAS)* [a] - *Global Assessment of Functioning (GAF)* [d,f]	Participants categorised at follow-up as 'relapsed' (score ≤ 3 on all BRS positive items for one month) or 'without relapse'. Between groups analyses (*chi2, Mann-Whitney U*) conducted on admission, discharge and follow-up variables. Correlations (*Spearman's*) conducted between DUP, PAS, clinical measures and GAF at follow-up. *Cox regression* to determine predictors of relapse. *Multiple regression* to determine predictors of GAF at follow-up. *Logistic regression* to determine predictors of employment at follow-up.	GAF at discharge: relapsed = without relapse. SANS at discharge: relapsed > without relapse z = -2.78, p < 0.01. No significant correlations between discharge scores and GAF at follow-up. GAF at discharge predicts employment at follow-up (B = -0.08, wald = 3.51, df = 1, p = 0.05).

* Due to the large number of statistical tests typically conducted in included studies, only those findings concerning the relationship between psychological state at discharge
[a] measures/assessment at admission
[d] measures/assessment at discharge
[f] measures/assessment at follow-up

Table 2: Study appraisal.

short reference	particpants	declined	outcome measures	blinding	risk factor measures	attrition	overall
Ceskova *et al.* (2007)	a	?	a	?	a	?	B1
Cougnard *et al.* (2006)	a	a, 0%	a	a	b1	a, 0.23%	A
Cuesta *et al.* (2006)	a	n/a	a	a	a	b2, 25.3%	B1
Hay *et al. (* 2003)	a	n/a	a	a	b1	b2, 38.1%	B1
Honkonen *et al.* (2007)	a	n/a	a	?	a	b2, 33%	B1
Huuhka *et al.* (2004)	a	n/a	a	?	a	a, 17.6%	A
Jager *et al.* (2003)	a	n/a	a	?	a	b1, 22%	A
Mellesdal *et al.* (2010)	a	n/a	a	?	a	a, 7%	A
Morrow-Howell *et al.* (2006)	b1	b1, 26.5%	a	?	a	a, 5%	B1
Prince (2005)	a	b1, 31%	a	?	a	a, 16%	B1
Qurashi, Kapur & Appleby (2006)	a	b1, 27%	a	b2	a	b1, 22%	B1
Salokangas, Honkonen & Stengard (2007)	a	n/a	a	?	a	b1, 23.1%	A
Smith *et al.* (2004)	a	?	a	?	a	?	B1
Tseng *et al.* (2006)	a	n/a	a	?	a	a, 20.9%	A
Ucok *et al.* (2006)	a	?	a	?	a	a, 10.8%	A

Chapter 2: Introduction to the Thesis.

At its outset, this project proposed to use mixed methods to address the following research questions:

- How do patients conceptualise the experience of discharge from an inpatient mental health unit?
- What role, if any, do measurable psychosocial constructs play in this conceptualisation?

Reducing acute inpatient readmissions has been designated a HEAT target by the Scottish Executive (Delivering for Mental Health, 2006). Ensuring that patients are adequately supported following discharge, and that the discharge itself is not unduly stressful, are key strategies in addressing this issue.

Simons *et al.* (2002) interviewed 173 former inpatient service users across eight Scottish health boards. The interview schedule was comprehensive, but highly structured and comprised of closed questions with a practical focus. The resulting data reflect these limitations. For example it is known that less than half of interviewees were fully satisfied with the discharge process. It is not known if or how this circumstance affected patient wellbeing or functioning. Conversely the Highland Users Group, a network of users of mental health services, published in 2003 the findings of a members' survey. The selected quotes clearly illustrate an emotional response to the discharge process (e.g. "You can feel cast out without even a goodbye and you can feel very apprehensive" p.7), but the report is descriptive and does not attempt to extrapolate from individuals' comments to a broader understanding of the discharge experience. It was anticipated that conducting a qualitative analysis of experience of the discharge period, combining detailed individual accounts with measures of psychosocial constructs understood to be associated with adjustment following an episode of acute mental illness, would bridge the gap between the two.

The purpose of the proposed project was to reach a fuller understanding of patients' experience of the period immediately prior to and following discharge. Such understanding might assist

subsequent patients and staff in anticipating and planning for difficulties at discharge, with the overarching goal of averting readmissions.

The function of the preceding systematic review of the literature was to extend and formalise the exploratory literature search which had already directed selection of standardised measures for inclusion in the quantitative portion of the project. The conclusions of the review were not as expected. Simultaneously, as is appropriate given the inductive nature of qualitative research methodology, the focus of the research evolved over the course of the project, in accordance with the comments and concerns of participants[2]. As will be seen, the resulting analysis pertains more to the engagement of patients in healthcare choices throughout the treatment process than it does to the specific experience of the post-discharge period. As a result the systematic review and the thesis - though sharing a common origin - now stand as distinct works, and the initiating research questions are not directly addressed by the resulting analysis.

There is a further modification to the reporting of the thesis. The project was originally conceived as a grounded theory project. Grounded theory is a qualitative methodology for the examination of basic social processes (Starks *et al.* 2007), such as the negotiation and adjustment to discharge from inpatient services. It seeks to answer the question 'What is happening here?' (Charmaz 2006) and to consider in detail the role of the context of social processes (how does it happen in *this* setting? How does it happen differently if this factor is changed?). Distinct from other qualitative approaches (e.g. phenomenological analysis) grounded theory seeks not only to describe in detail, but to develop an *explanatory framework* (Starks *et al.* 2007). In clinical terms this is analogous to the progression from a descriptive list of a patient's presenting

[2] A core feature of inductive research methodology is that the literature review is conducted after analysis, to ensure that the developing analysis is not unduly influenced by preconceived ideas (e.g. Glaser & Strauss, 1967; Charmaz, 2006). Several authors (e.g. Suddaby, 2006) have commented upon the misrepresentation of inductive methods which occurs when conventional journal article format requires the researcher to produce an introductory literature review. This thesis will not replicate such misrepresentation, but rather will consider themes in the context of relevant concepts in the extant literature as the analysis is presented in the results chapter. This format is retained in the final chapter, where results are presented in accordance with guidelines for *Psychology and Psychotherapy: Theory, Research and Practice* (see Appendix 2).

problems and attributes, to a *formulation* of their difficulties, which considers any causal, meditational and other relationships between them. A grounded theory 'formulation' of a social process in a particular setting (e.g. a mental health unit) is referred to as a 'substantive theory'. Where the theory can be abstracted to other settings (e.g. a more general theory of adjustment to mental ill health) this is referred to as a 'formal theory'. In clinical terms this may be analogous to the development of a theoretical model of a disorder derived from an in-depth exploration of commonalities and differences between numerous patients' formulations.

As with a clinical formulation, the value of a substantive grounded theory is that it not only describes and promotes understanding of the process in question, but indicates potential points to intervene in the process and by implication improve it. For this reason grounded theory was selected as particularly appropriate for this thesis project, where the broader aim was understanding and *optimising* of the discharge experience.

The project was therefore designed and conducted in accordance with grounded theory methodology, to the best of the researcher's ability. This is reflected in Chapter 3 (Methods) which gives an account of the researcher's understanding and implementation of such grounded theory methods as concurrent data gathering and analysis, constant comparison and memo-writing. However, restrictions to the recruitment process meant that it was not possible to conduct theoretical sampling, perhaps the *hallmark* method of grounded theory (the reasons for and implications of this restriction are discussed in greater detail in chapters 3 and 6). The researcher was not able to selectively pursue participants who might 'speak to' a particular aspect of the developing analysis, but instead was dependent on a self-selected, voluntary participant group who – perfectly rightly – had their own concerns re the discharge process and may not have had experiences relevant to the developing analysis.

As a result the data were broad ranging, but were lacking in depth and relevant detail, and this has restricted the analytic possibilities. A number of themes were constructed from interview data and these themes are described in detail. Possible relationships between the themes are also identified and described. However, themes and relationships are insufficiently comprehensive and coherent to progress the analysis to an *explanatory framework*. As such the analysis cannot

properly be described as a grounded theory, but more closely approximates a thematic analysis. To return to the clinical analogy, what has been produced is a detailed account of presenting problems which require some further assessment before a formulation can be generated. To reflect this limitation, Chapter 4 (Findings) refers to the products of the analysis as 'themes' in contrast to the 'categories' which were anticipated in Chapter 3 (Methods).

The failure to attain the original goal of generation of a grounded theory need not invalidate the findings of the project as they stand. The current analysis may be regarded as a preliminary analysis, identifying themes which (were restrictions to recruitment to be repealed) further data gathering and analysis may subsequently progress to the status of categories and concepts. Alternatively, the findings may be regarded as a Thematic Analysis in their own right.

Thematic analysis as a research methodology is less clearly defined than grounded theory, its flexibility being regarded as an asset (Braun & Clarke, 2006). However the two methodologies have many commonalities, including emphasis on the importance of articulating one's epistemological stance (particularly with respect to the role of the researcher); the value of richly detailed data; a recursive or iterative approach to coding and categorising/theme development; and the value of balancing abstraction of key concepts with retention of context (Braun & Clarke, 2006; Ezzy, 2002). In effect, no aspect of the research process as it was conducted is incompatible with a thematic analytical approach, and thus the presentation of the findings as a thematic analysis (Chapter 7, Journal Article), despite the apparent discrepancy with the preceding description of the methods as grounded theory, is not inappropriate.

It is certainly the case that the product of this research project differs considerably from that which was anticipated at its conception. Some variation is due to aspects of the study design, such as the restriction to recruitment, which should perhaps have been foreseen. Some due to unforeseeable factors such as the content of participant interviews. Despite these variations, it is believed that the overarching research aim, that of improving understanding of the discharge experience and identifying means of promoting appropriate engagement with patients, has been met by this evolved project.

Chapter 3: Methods

Design: Mixed Methods

This project has employed an embedded mixed methods design, a design in which one method of data collection or analysis plays a supplementary role within a methodology framed by another (Caracelli & Greene, 1997, cited in Cresswell & Plano Clark, 2007; Onwuegbuzie & Leech, 2006). In this instance the primary method of data collection was qualitative: participants' principal contribution was an in-depth interview about their inpatient experience. The secondary method of data collection was quantitative: participants also completed a selection of standardised assessments of psychosocial constructs previously found to be associated with outcome of inpatient psychiatric care. Data were gathered concurrently and were integrated at analysis. This is described in greater detail below.

The embedding of quantitative data in a qualitative project (QUAL(quan); Morse, 1991a) is unusual, though not unprecedented (e.g. Teno *et al.,* 1998). The rationale for inclusion was two-fold. Firstly for logistical reasons, prior research suggests that certain constructs, like attachment or illness perceptions, would influence the way in which participants experienced and thus described their inpatient treatment (e.g. Adshead, 1998; Sayre, 2000). The project was limited in time and resources, and inclusion of brief measures of these constructs would render it unnecessary to directly address these themes in interview and re-construct them from interview data. Secondly, comparing and contrasting constructed categories with ratings of existing constructs would provide an additional means of validating categories and permit triangulation within extant theory (Cresswell & Plano Clark, 2007). This would be particularly valuable in a subject area where comparable research is scarce.

Writers in the area of mixed methods research (e.g. Cresswell & Plano Clark 2007) have stressed the particular importance of explicating one's epistemological position when reporting on mixed methods research. This project has been developed and conducted from a *social constructionist* stance.

Epistemology: Social Constructionism

Social constructionism is 'a theoretical approach which regards certain aspects of human experience and knowledge as originating within and cultivated by society or a particular social group, rather than existing inherently or naturally' ('social constructionism', 2011). It is often described as derived from a relativist ontological position, (e.g. Burr, 2003) though other writers have remarked that it makes no assertions about the nature of reality, only of knowledge (e.g. that the *knowledges* 'the glass is half full' and 'the glass is half empty' are equally true makes no suppositions about whether or not the glass *exists*; from Willig, 2008). Social constructionism underpins an array of research methodologies across several disciplines - e.g. psychology, sociology, history, literature - but Burr (2003) has identified four 'definitive' common attributes:

- *'A critical stance to taken for granted knowledge' (p.2).* Though the categories with which we divide and define ourselves and the world (e.g. species, furniture) may appear self evident, in fact they reflect shared meaning not necessarily real distinctions. Social constructionist research examines the establishment and implications of these definitions, and the potential implications of alternative categories.
- *'Historical and cultural specificity' (p.3).* Shared meanings are unique to the time and place of their development. They are both products and producers of their cultural and economic context. Social constructionist research explicitly acknowledges the limitations of its applicability outwith its context of origin, and makes no claims that current knowledge is more 'accurate' or 'better' than that of other eras or cultures.
- *'Knowledge is sustained by social processes' (p.4).* Knowledge is not obtained by objective perception of 'real' things (empiricism) but by the communication and negotiation of meanings between people (e.g. an item is known to be a *chair* not by its shape or material, but because I invite you to sit on it). Social constructionist research attempts to elucidate the social processes by which meaning is negotiated.
- *Knowledge and social action go together' (p.5).* There is a reciprocal relationship between what is known in a specific context and what is or can be done. Social constructionist research challenges the limits of social actions by querying the knowledge within which they take place.

The inclusion of quantitative data in a project with a social constructionist basis is controversial. Some consider that social constructionism:

> ...is not compatible with methods which are designed to measure variables in a population. This is because social constructionism problematizes given constructs such as 'psychological variables'; it questions their validity. (Willig, 2008, p.8)

This project takes the stance that the two are reconcilable if one explicitly acknowledges that the characteristics being measured are themselves social constructions. That is, one does not propose that measures of psychopathology or relationship styles reflect immutable features of a population, but rather that they delineate meanings – arguably - so widely shared within the psychological research community as to constitute knowledge. Standardised measures are used in this project to facilitate the integration of extant constructions into a new theory. By administering a measure of depression we are not assigning a participant to a *population* that 'is' or 'is not' depressed, but rather enquiring of an *individual* to what extent the previously constructed concept 'depression' adequately describes or reflects their own experience.

Methodology: Grounded Theory

Grounded theory was introduced by Glaser and Strauss (*The Discovery of Grounded Theory,* 1967) as a challenge to the perceived hegemony of hypothetico-deductivism, which they regarded restricting the rate and scope of knowledge acquisition by consigning the majority of researchers to a career testing theories proposed by an elite few. Combining backgrounds in ethnography and empiricism they suggested that by gathering rich data in social settings, codifying meanings and systematically abstracting to inter-related concepts it was possible to generate new theories of social processes which were grounded in the data rather than hypothesised.

Glaser conceived and continues to defend grounded theory as a positivist methodology: there *are* latent patterns in social processes and the application of grounded theory methods allows the

researcher to uncover and abstract them in an objective manner (Glaser, 2002). Other researchers have challenged the role of the researcher as unbiased revealer of knowledge (e.g. Kelle, 2005). Prominent among these is Charmaz (1990, 2006) the chief proponent of social constructivist grounded theory. While sharing core methods, the primary distinctions between social constructivist and positivist grounded theory are:

- *Emphasis on the role of the researcher*. The researcher does not simply convey the participants' constructions, but co-constructs them throughout the data-gathering, interpretation and reporting stages. The researcher will make explicit reference to their own background and presuppositions, and consider how these have influenced their construction (not discovery) of the theory.
- *Emphasis on the specific context of the theory.* While 'original' grounded theory aims to abstract social processes beyond the observed setting (formal theory), social constructionist researchers regard theories as being strengthened by being situated in a particular time and place. The researcher will make explicit reference to the relationship between the constructed theory and the social conditions in which it originates.

Methods: Qualitative

The process of grounded theory is cyclical not linear, complicating division into 'steps' and resulting in different authors adopting different explanatory frameworks. However there are core methods – specific tools of research – which define grounded theory as a methodology. The following synthesises descriptions from a number of sources (Charmaz, 1990, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Willig, 2008) and describes the application in this project.

Gathering rich data:

The principal mode of data collection was by individual, face-to-face, intensive interviews. Multiple sources were consulted with a view to optimising the quality of the data obtained from interviews, including Evans (2007) on methods of promoting a comfortable interview climate, and Charmaz (1990) and Rubin and Rubin (2005) on the appropriate inclusion of face-sheet,

informational, reflective, feeling and ending questions. Interviews followed a semi-structured format, i.e. while the researcher had developed broad questions to direct the interview to *a priori* areas of interest, participants were encouraged to be as expansive as possible on points arising and more detailed probe questions were generated *ad hoc*. In keeping with the grounded theory method, interview schedules evolved over the course of the project as topics of interest were identified and elaborated. In later interviews questions often took the form of asking participants to comment on the researcher's thoughts about the developing theory. Examples of an early initial interview schedule and a later follow-up interview schedule can be seen in Appendix 3.

Theoretical sampling:

Theoretical sampling is the strategic recruitment of specific people whose knowledge is pertinent to the developing theoretical categories. Opportunity for theoretical sampling in this project was limited, as professionals in the research setting had reservations about approaching specific individuals, concerned that potentially vulnerable people may feel pressurised to participate (see Ethical considerations below). The project sample is thus more accurately described as a purposive sample: eligibility criteria are determined at the outset to target a population able to inform on the topic (e.g. sampling inpatients to learn about discharge) but are not modified during the course of the project (Morse, 1991b, cited in Jeon, 2004). The ramifications of this are considered in the Discussion chapter.

Coding and categorising:

Coding is the application of a label to a piece of data which briefly summarises its meaning. Initial coding of early interview transcripts usually takes place line-by-line, with each line being accorded equal importance and closely scrutinised. This process generates numerous 'initial codes' and ensures that all possibilities for theorising are considered. Following Charmaz (2006) effort was made in this project to keep initial codes richly descriptive and action-oriented to direct the focus of later analysis towards processes not occurrences.

In the second stage of coding, initial codes are assembled into 'categories' of codes with shared meaning. Theoretical sensitivity, a sense of which categories are most salient to the research question and to participants, alerts the researcher to which categories or 'focussed codes' should be retained. These categories form the focus of subsequent interviews and in doing so an increasing degree of detail about them is acquired. Categories are defined and delineated in terms of their properties (what does this code describe? to whom does it apply? under what conditions?) and this may lead to the construction of subcategories. They are also considered in terms of their relationships with other categories (are they part of a linear process? are they discrete or do they form a continuum?) and this may lead to the construction of super-ordinate categories or themes. Themes may cluster together and theoretical relationships between them may be identified and elaborated. A 'coding structure' is thus developed. A more detailed account of construction of codes in this project is offered below.

Constant comparison:

The development of the coding structure is not linear. Constant comparison is the process of continually revisiting the data one has as well as considering new data, and asking questions about the two: how is this new incident similar to those already coded? How is it different? Is this incident sufficiently similar to join this category or is a new category indicated? Categories are therefore continually not only constructed, but deconstructed and reconstructed. In this way the researcher 'stays close' to the data, and the developing categories are grounded in the data. Relationships between categories are also subject to continuous examination and questioning; if under condition A the relationship between B and C is D, what is the relationship under newly arising condition E (where each letter represents a code or category)? Comparison continues beyond the construction of theory, when the theory itself is compared with existing literature – both qualitative and quantitative – to determine if and how it replicates, refutes, extends or enhances existing understanding in the subject area (Charmaz, 2006). Again a more detailed account of the process in this project is given below.

Memo Writing:

Memos are where much of the work of grounded theory takes place. Effectively a series of 'notes to self', they record the researcher's interactions with the data. They are central to the reflective process, being the forum in which the researcher can relate their personal experience and theoretical knowledge of the research area to their gathered data and developing analysis. They can range in length and formality from a scribbled note or question to a lengthy analysis of a complex inter-category relationship, and may be made at any time and in any medium. Collated and organised, key memos can form an early draft of a report. Preserving a complete archive of memos is essential in demonstrating analytical rigour (see below). An example of a handwritten memo from midway through the project is given in Appendix 4.

Literature Review:

The 'disputed' literature review is a controversial matter in grounded theory. Though the *fundamental premise* of the methodology is that concepts should be derived from the data and not imported from extant theories - to which end the researcher should try to remain free of, or at least aware of, preconceptions - this has frequently been misinterpreted to mean that an understanding and discussion of existing writings in the field is unnecessary (e.g. Suddaby, 2006). This is not the case. As with any research it is necessary to indicate its value (different to statistical *validity*) and usefulness to those whom it purports to serve, and this cannot be done without comparison to existing theory and practice. In this project, a general understanding of some of the psychological constructs pertinent to inpatient treatment and discharge was necessary in order to select measures and generate a research proposal. Detailed examination of the literature however was postponed until after the development of categories.

Methods: Quantitative

Glaser and Strauss discussed the use of quantitative data to generate grounded theory in their original text (1967). The premise is as follows. A quantitative variable, whether at the scale, subscale or item level, is considered a 'category'. Participant's scores can be used 'raw' or divided into two or more nominal or ordinal groups (e.g. participants responding 'yes' or 'no'; low, medium and high happiness etc). One can then cross-tabulate every variable with every

other variable, seeking patterns in relationships between them (constant comparison). In hypothetico-deductive analysis one can describe only the 'facts' of a relationship – participants who said 'yes' they had finished their thesis were more likely to be happy. Grounded theory permits one to make *theoretical inferences* about the relationship – participants were happier *because* they had finished their thesis. Relationships can themselves be compared, and complex inter-relationships may ultimately coalesce into an integrated theory. A variable which show no relationships (i.e. there is no difference between the 'yes's and the 'no's on any other variable in cross-tabulation) is not relevant to the theory and can be excluded.

To facilitate the generation of theory, Glaser and Strauss proposed "a careful relaxation of rules surrounding quantitative analysis" (1967, p. 210). What is of interest is the relationship between variables and the inferences that can be drawn from these, *not* the precise measurement of participants or the statistical significance of differences. The theorist is therefore not constrained to select measures on the basis of validity and reliability, but should do so on the basis of theoretical interest. Similarly, the selection of cut-offs or division of groups within categories or measures need not be driven by considerations of sensitivity or specificity, as 'crude' indices are sufficient to illustrate the general relationship which is of interest.

A variant of this process was applied in this mixed methods study. Categories generated from interview data were cross-referenced with scores from quantitative variables. In this case however the function of the quantitative variables was to facilitate connection of the constructed categories to existing literature. As such – although all possible relationships between qualitative and quantitative categories were calculated and briefly inspected – close examination and discussion only occurred where a relationship supported or contradicted findings previously reported. Again this process is described in greater detail and exemplified below.

Standardised measures:

Standardised measures were selected to cover a range of factors understood to be associated with adjustment to an episode of acute mental illness. Specific measures were selected for brevity and face validity, to facilitate comprehension and completion by participants. Demographic and

historical information; participants' age; gender; reason for admission; duration of admission; number of prior admissions in last three years; and total duration of admissions in past three years, was gathered by means of a personal information form incorporated into the standardised assessment pack (see Appendix 5). These were variables found to be predictive of readmission (a gross indicator of outcome) in the Scottish Patients at Risk of Readmission project (SPARRA; Information Services Division, 2009). The standardised assessments comprised:

- *The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983).* Despite improving during admission, psychiatric inpatients typically continue to experience clinically significant levels of psychological distress at time of discharge (e.g. Tseng *et al.,* 2006). General psychopathology has been observed to be more strongly associated with perceived quality of life than positive and negative symptoms of schizophrenia in people with related diagnoses (Huppert *et al.,* 2002). The HADS is a widely used measure of symptoms of anxiety and depression. Extensive literature review suggests the HADS is a valid and reliable indicator of presence and severity of anxiety and depression in general population, medical and psychiatric samples (Bjelland *et al.*, 2002). Participants endorse one of four statements which best corresponds to their experience of seven symptoms in each of two subscales, depression and anxiety. More severe symptomatology generates a higher item score. A numerical score (range 0 – 21) for each subscale is obtained by summing item scores.

- *The Significant Others Scale (SOS; Power et al., 1988).* Social support provides care, love, esteem and a sense of belonging – all moderators of stress (Dickinson *et al.,* 2002). Experience of supportive social interactions has been shown to be linked to increased perceived quality of life in people with severe mental illness (Yanos *et al.*, 2001). Those recently discharged from inpatient care have been shown to have smaller support networks than outpatient service users (Dickinson *et al.,* 2002) and lower levels of social support have been linked to increased risk of suicide in the year following discharge (Troister *et al.*, 2008). The measure has been used successfully with a range of clinical samples (e.g. Baynes *et al.,* 2000). The SOS asks participants to select up to seven significant others and use a seven-point Likert scale to rate their actual and ideal input on

four domains of support; sharing feelings, practical support, times of difficulty and social time. These dual ratings permit examination of any discrepancy. Rich information about participants' social networks is attainable in a brief and simple measure, and the SOS has been selected for this reason. A numerical (range 1 to 7) score for actual, ideal and discrepancy for each of the four domains is obtained by calculating the mean response across identified significant others. Additionally, number of significant persons identified was created as an ordinal category, and whether the identified significant others included mental health staff was created as a dichotomous category.

- *The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994a).* Insecure attachment style is a risk factor for psychopathology in the general population (Ward *et al.*, 2006); is associated with recovery style following episodes of psychosis (Tait *et al.*, 2004) and is predictive of outcomes such as social adjustment and suicide attempt in the period following episodes of major depression (Grunebaum *et al.* 2009). The RSQ is the most widely used self report measure of attachment style and well validated (e.g. Guedeny *et al.*, 2010; Ma, 2006) and has been used with a range of clinical samples. Participants rate thirty statements on a seven-point Likert scale. As well as novel items, the scale includes items from pre-existing attachment measures (e.g. Adult Attachment Questionnaire; Hazan & Shaver, 1987) and a wide range of subscales are calculable, some more statistically reliable than others (Kurdek, 2002).

  This project adopted Griffin & Bartholomew's (1994b) four category model, wherein positive or negative internal working models of self and other are cross tabulated to produce four attachment styles; secure (self positive, other positive); preoccupied (self negative, other positive); dismissive (self positive, other negative) and fearful (self negative, other negative). A numerical score (range 1 to 7) is obtained for each attachment style by calculating the mean rating of relevant items.

- *The Personal Beliefs about Illness Questionnaire (PBIQ; Birchwood et al., 1993).* The social cognitive model posits that individuals internalise negative social stereotypes of mental illness, and on experiencing mental illness these become salient as beliefs about

self, with negative emotional and behavioural consequences (e.g. Camp *et al.*, 2002). Negative appraisals of mental illness have been associated with a range of outcomes, including increased incidence of comorbid anxiety or affective disorders (Karatzias *et al.,* 2007), poorer perceived quality of life and reduced psychosocial functioning (Lobban *et al.*, 2004) and greater perception of unmet need (Broadbent *et al*., 2008) following acute mental illness. The PBIQ measures five domains of negative illness beliefs; loss, humiliation, shame, attribution of behaviour to self or illness and entrapment. The scale has shown good reliability and validity with people with psychosis – for whom it was originally developed – but has also been used successfully with people with mood disorder (e.g. Sherwood *et al.*, 2007). Participants rate a total of 16 problem statements on a four point scale from 'strongly disagree' to 'strongly agree'. Greater agreement generates a higher item score. A numerical score (range variable due to differing item numbers) for each subscale is obtained by summing item scores.

The Research Process:

Setting:

Huntlyburn is NHS Borders' inpatient mental health unit. Its 26 beds are available to adults (16-69 years), older adults (≥70 years) and adults with learning disability who are in the acute phase of mental disorder. It also offers planned admission for drug and alcohol detoxification, and to people with a diagnosis of borderline personality disorder.

Huntlyburn is a nurse-led unit, with patient care overseen by community based consultant psychiatrists who attend twice-weekly ward rounds. In the period January to December 2010, there were 213 'emergency' admissions and 83 'planned' admissions. Approximately half (51.1%) of admitted patients were male. The duration of admission for the 303 patients discharged during the same period is illustrated in Figure 3.1.

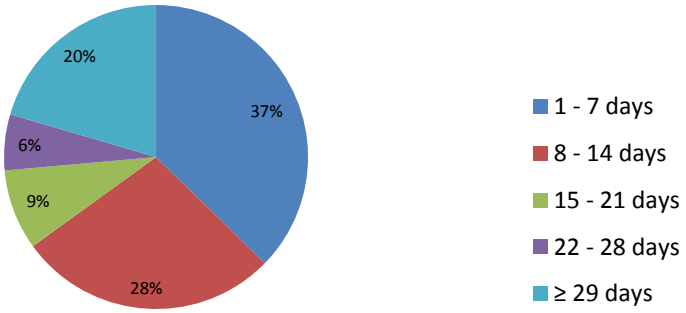


Figure 3.1: Length of patient stays, Huntlyburn, January 2010 to Deccember 2010.

Eligibility:

All adult inpatients of Huntlyburn who were resident for seven or more days were eligible for inclusion, providing they were deemed capable of consenting to participation by their admitting doctor. Potential limitations to capacity to consent are assessed and recorded as part of the admission procedure. None were observed with regard to any of the people who were willing to participate.

Recruitment:

Recruitment took place in the period September 2010 to April 2011. Patients were made aware of the project by means of a poster displayed on ward notice boards (see Appendix 6). An invitation to participate was included as a recurring agenda item at the weekly ward community group meeting. The participant information leaflet (see Appendix 7) was freely available on the ward.

Establishing consent:

People indicating interest in participation were provided with a participant information leaflet, and given the opportunity to ask questions of the researcher. Those with a continuing interest were given a minimum period of 24 hours to reflect on this information, before again being

offered the opportunity to ask questions. Those willing to participate were asked to complete a consent form (see Appendix 8).

Completion of Standardised Measures:

Having given written consent, participants were provided with the standardised assessment materials, and an initial interview was scheduled. Participants could choose to complete the measures prior to the interview, or to enlist the support of the researcher in completing measures during the interview session.

Interviews:

Initial interviews were scheduled to take place at or close to the time of discharge (N = 12, median 0.5 days, range 0-13), follow-up interviews were scheduled to take place approximately 4 weeks post-discharge (N = 11[3], median 28 days, range 19-52). Initial interviews took place on the ward, or an alternative location of the participants' choosing, follow-up interviews took place at the participants' local health centre or an alternative location of the participants' choosing. Alternative locations included participants' homes, and local cafes, and interviews were arranged in accordance with relevant departmental risk management protocols (i.e. NHS Borders' Personal Safety Guidelines; NHS Borders, 2009). Participants were advised at recruitment that initial interviews would take approximately 1 hour, and follow-up interviews approximately ½ hour, dependent on their own contribution. The mean duration of initial interviews was 53 minutes (S.D. 19 minutes, range 20 – 98 minutes) and of follow-up interviews was 53 minutes (S.D 10 minutes, range 39 – 76 minutes). Observational notes on non-verbal aspects of participants' communication and demeanour were made immediately following interviews, and were appended to interview transcripts.

It was initially supposed that the initial interview would be a prospective discussion of participants' plans, hopes, concerns etc for the discharge period, while the follow-up interview would be retrospective discussion of the discharge experience. It was therefore planned that the

[3] Note that one participant – participant K – was unavailable for follow-up interview.

initial and follow-up interviews would be analysed separately. As the project progressed however, it became apparent that participants were using both interviews retrospectively, to tell the story of their illness and admission, and relate their experience of the ward. The function of the follow-up interview was adjusted, now serving as an opportunity to probe in detail topics raised in the initial interview and identified as important during researcher reflection. Initial and follow-up interviews were then analysed together.

Data:

Interviews were recorded using a digital voice recorder (Olympus VN-5500PC). On the day of interview a single hard (CD) copy of the audio recording was created and stored securely with the participant's completed consent form and standardised assessments in a locked cabinet on NHS Borders' premises. Interviews were transcribed by the researcher in accordance with guidelines laid out by McLellan *et al.* (2003) which include steps to appropriately anonymise the transcript. Following transcription the digital recording of the interview was destroyed.

Data analysis was supported by the research support software NVivo 8 (QSR International 2008). Interview transcripts and observational notes were imported into the software as texts, allowing them to be coded, and codes to be subsequently categorised and structured as per the grounded theory method. Memos can be written, stored, updated and cross-referenced by the programme. NVivo is particularly useful with this mixed methods design. A 'case' was created for each participant, and demographic data and responses to standardised assessments were entered as case attributes. This permitted - for any given code or category - either responses of all contributors to a particular standardised measure or the responses of a particular contributor to all standardised measures, to be easily viewed, facilitating the linking of qualitative and quantitative categories. Screenshot examples of line-by-line coding, categories, memos and the casebook are given in Appendix 9.

Ensuring Analytical Rigour

Grounded theory texts often carry the implicit (and sometimes explicit; e.g. Glaser, 2002) assumption that where grounded theory methods are properly applied, the resulting theory will be of high 'quality' (the evaluation of which will be addressed in the discussion). Thus it is of critical importance that one is able both to be rigorous and to evidence one's rigour and – in the case of social constructivist grounded theory – to be reflexive and to evidence one's reflexivity (Charmaz, 2006; Corbin & Strauss, 2008; Starks & Trinidad, 2007; Suddaby, 2006). In this project the following steps were taken to meet this aim:

- Keeping a reflective journal throughout the project. Though the reflective statement gives the impression of being a singular event, in fact it is drawn from an accumulation of reflective observations, commenced at the outset of the project.
- Consulting with participants or 'member-checking'. Interview schedules for later participants often involved asking them to comment on the current form of the developing theory.
- Consulting with colleagues and supervisors. Regular formal meetings with academic and clinical supervisors as well as informal contact with ward staff were utilised to gain alternative perspectives and provide a counterpoint to researcher bias[4]. Formal comments on drafts of the findings were sought and received from nursing staff, ward management and consultant psychiatrists.
- Maintaining an audit trail. The use of NVivo for generating and storing coding structures and memos generates a self-updating audit trail. Hard copy backups of project file were made at various key points in the project to supplement this, and an archive of handwritten observations has been maintained.

Ethical Considerations:

[4] Note that a social constructionist epistemology problematises the concept of inter-rater reliability. The measurement of correspondence between the coding or categorising of two or more researchers is only meaningful if one presupposes that they are examining the same objective reality (positivism) and that the degree of correspondence therefore reflects the accuracy of each. While it would in theory be possible for two researchers within a social constructionist paradigm to 'construct' the same theory this would not make the theory itself any more 'objective' or 'true', it would simply be the subjective interpretation of two people (Yardley, 2000).

Consideration of potential ethical issues at the research design stage identified three issues, which were pre-emptively managed as follows:

- *People may have felt obligated to participate.* Invitations to participate asked interested people to approach the researcher, neither the researcher nor ward staff directly requested the participation of any person. The voluntary nature of participation was highlighted at the point of invitation, explicitly stating that access to and/or quality of subsequent care would not be impacted by the decision to take part or otherwise. Having initially consented, participants were reminded at each contact of their right to withdraw at any point, and to have any comment or response stricken from their record at their request.

- *Risk or safety issues may have been identified in questionnaire or interview responses of which ward or community staff were previously unaware.* At each point of contact participants were reminded of the limits of confidentiality, and that any disclosures of risk to self or others would be passed to the appropriate services, where possible with their consent. Where participants disclose an immediate risk, this would be handled in accordance with existing departmental protocols. This situation did not arise in the course of the project.

- *The project may have been misinterpreted as a source of psychological therapy or ongoing support.* It was stressed in participant information materials that the interviews were for research purposes only, and the researcher was not in a position to offer psychological assessment or intervention, nor would additional contacts be available. Where unmet support needs were identified in standardised assessment or at interview, this information would be shared with the participant's community support team (with participant consent). This situation did not arise in the course of the project.

Ethical approval for the project was sought from the DClinPsychol Research Ethics Committee at the University of Edinburgh, which identified no complex ethical issues. Further submission for ethical approval was made to the South East Scotland Research Ethics Committee (SESREC; reference 10/S1103/39) via the Integrated Research Application System (IRAS). The project

was approved subsequent to minor amendments. Management approval for the project was sought, and obtained, from NHS Borders Research Governance Committee. Copies of the decisions of each committee can be seen in Appendix 10.

Sample:

A total of 12 people consented to take part, and their characteristics are briefly summarised in Table 3.1. In order to preserve context by constant reminder that these are individuals' narratives (in keeping with the social constructionist approach), participants are referred to throughout by a pseudonym rather than a number or code.

Table 3.1: Sample characteristics

Participant	Pseudonym	Gender	Age	Reason for admission (self-defined)
A	Angela	Female	30-39	Complex care plan
B	Brian	Male	60-69	Depression/anxiety
C	Colin	Male	50-59	Depression
D	Derek	Male	50-59	Depression/emotional distress
E	Ellie	Female	40-49	Alcohol detox
F	Fiona	Female	18-29	Depression
G	Gillian	Female	40-49	Hypermania
H	Henry	Male	30-39	Mania/suicidality
I	Isla	Female	50-59	Depression
J	Jack	Male	30-39	Attempted suicide
K	Ken	Male	50-59	Schizophrenia
L	Linda	Female	50-59	Depression/suicidality

An account of the research process:

At the outset of the project, there was considerable interest, and five participants (A to E) were recruited and interviewed in relatively rapid succession. The combination of pressure of time on

transcription and initial coding, and a novice interviewer's failure to adequately direct and focus interviews, meant that the resulting data were fairly scant and diverse in content. Though line-by-line coding was conducted on all ten interviews, it was difficult to construct any categories or themes which would cohere without excluding many other avenues of analytical pursuit. Kelle, writing about his own early experiences of grounded theory, summarised the predicament:

> ...in the beginning we had the understanding that 'everything counts' and 'everything is important' – every yet marginal incident and phenomenon was coded, recorded in numerous memos and extensively discussed. This led to an insurmountable mass of data… (Kelle *et al*., 2002, cited in Kelle, 2005)

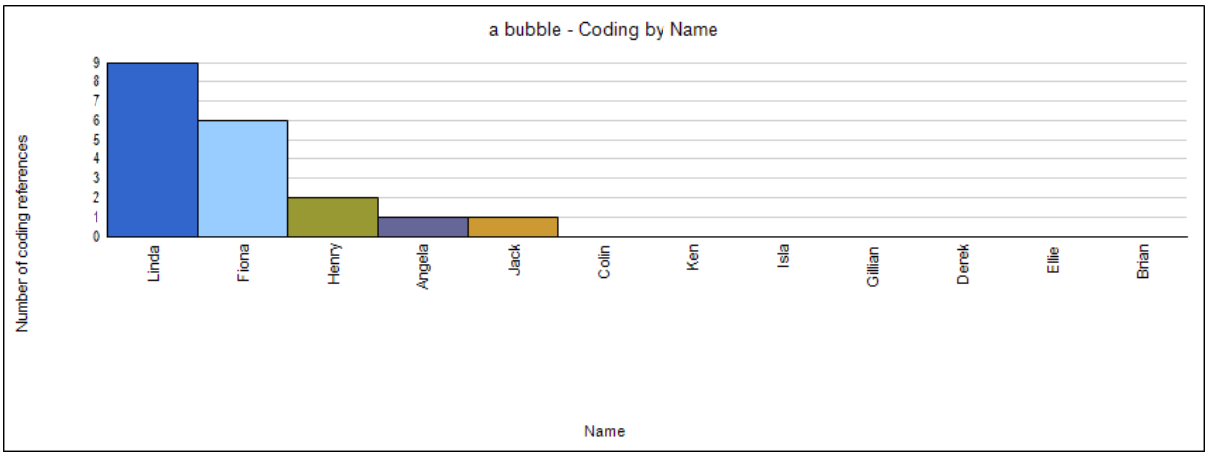
A decision was taken to select one area of interest from the existing interviews – decision making had been referenced by all participants to date – and, having worked on improving interview skills, to conduct further interviews but return to line-by-line coding. Three further participants were recruited, and line-by-line coding of their contributions generated a total of 896 initial codes. This time, after multiple iterations, around two thirds of the initial codes were incorporated into a series of 50 focussed codes under the broad headings of attributions, choice, emotional drivers, faculties, illness identity and presentation of choices. Returning to the transcripts from participants A through E, these focussed codes were discernible in each narrative though they had not been specifically sought in interview, suggesting that these early categories were salient to participants.

With interviews from eight participants coded into this structure, a further four participants were recruited, whose interviews were structured to develop the themes of choice, engagement and illness identity. While these were in progress, the coding structure itself was under constant de/reconstruction, for example the codes 'open choice' and 'closed choice' (among others) were merged to form the larger category 'having choices'. Conversely the category of 'moral obligations' was added to the coding structure in response to later participants' comments, but subsequently divided into two subcategories when references sought in earlier interviews suggested that two distinct forms of 'obligation' were felt. Codes which were found to be scant or irrelevant were 'de-constructed', their constituent initial codes incorporated into retained categories or re-assigned to the 'free codes' not included in the coding structure. Records of the

rationale and timing of all such decisions were maintained in memos, which also recorded descriptions and analytical queries about the retained codes.

The evolution (though perhaps given the active role of the researcher the term should be 'selective breeding') of codes and categories continued past the end of the data gathering phase. As each section of transcript under each code was scrutinised to determine how it exemplified the category and illustrated inter-category links, categories continued to be merged, subdivided and re-positioned with the structure. For example it was only in the final stages that the category of 'engagement' was relocated under the 'relating to staff' heading (having previously been located under 'facing choices') and that the categories originally entitled 'negotiating' and 'complying' were renamed 'co-operating' and 'cooperating' to more accurately reflect the easily overlooked distinction between the two. A representation of the final coding structure can be seen in Appendix 11.

Having constructed and mapped qualitative categories, these were integrated with participants' quantitative data. Using NVivo's chart function it was possible to graphically represent each participant's contribution to each qualitative category. For each category, participants were divided into two groups, those who were 'significant contributors' (i.e. their narratives had make frequent or notable reference to the category) and those who were not. For example Figure 2 illustrates that Linda, Fiona, Henry, Jack and Angela were contributors to the category of *the ward as a bubble*. Their scores on standardised measures were then compared to those of the group of non-contributors (it is observed that they score more highly on measures of anxiety, 12.8 compared to 11.0, and depression, 10.8 compared to 7.1, and are less satisfied with their current levels of social support, for example 0.8 compared to -0.8 for practical help). Theoretical inferences were then drawn about why these differences may have been observed: perhaps a perceived deficit in social support heightens subjective distress in response to stressors and the ward is then positively regarded as a place where stressors can be avoided.



pseudonym	Linda	Fiona	Henry	Angela	Jack	Colin	Ken	Isla	Gillian	Derek	Ellen	Brian	high contributor mean	low contributor mean	high contributor median	low contributor median
age	50-59	18-29	30-39	30-39	30-39	50-59	50-59	50-59	40-49	50-59	40-49	60-69				
gender	Female	Female	Male	Female	Male	Male	Male	Female	Female	Male	Female	Male				
length of admission	48.0	17.0	11.0	7.0	11.0	50.0	111.0	42.0	32.0	13.0	12.0	48.0	18.4	44.0	11.0	42.0
prior admissions	0.0	0.0	4+	3.0	0.0	0.0	1.0	1.0	4+	1.0	4+	0.0	0.8	0.6	0.0	1.0
total time admitted	48.0	17.0	127.0	92.0	11.0	50.0	123.0	84.0	363.0	19.0	57.0	48.0	58.6	106.3	46.0	57.0
HADS Anxiety	14.0	8.0	10.0	20.0	12.0	11.0	15.0	8.0	18.0	7.0	11.0	7.0	12.8	11.0	12.0	11.0
HADS Depression	12.0	7.0	11.0	15.0	9.0	8.0	7.0	6.5	17.0	2.0	4.0	5.0	10.8	7.1	11.0	6.5
number of sig others	4.0	3.0	3.0	5.0	3.0	4.0	3.0	7.0	3.0	1.0	4.0	3.0	3.6	3.6	3.0	3.0
sig others includes staff?	yes	no	yes	no	no	yes	no	yes	no	no	yes	no				
share feelings actual	5.8	6.0	6.0	5.8	4.0	6.3	7.0	5.8	2.0	7.0	5.5	7.0	5.5	5.8	5.8	6.3
share feelings ideal	6.5	7.0	7.0	6.6	5.3	6.8	7.0	6.2	2.0	4.0	7.0	7.0	6.5	5.7	6.6	6.8
share feelings discrepancy	0.8	1.0	1.0	0.8	1.3	0.5	0.0	0.3	0.0	-3.0	1.5	0.0	1.0	-0.1	1.0	0.0
times of difficulty actual	6.3	4.7	6.3	6.4	2.7	6.8	7.0	5.4	4.7	4.0	6.0	7.0	5.3	5.8	6.3	6.0
times of difficulty ideal	6.5	5.3	7.0	6.8	4.0	6.8	7.0	5.7	1.0	4.0	6.8	7.0	5.9	5.5	6.5	6.8
times of difficulty discrepancy	0.3	0.7	0.7	0.4	1.3	0.0	0.0	0.3	-3.7	0.0	0.8	0.0	0.7	-0.4	0.7	0.0
practical help actual	5.3	1.3	6.3	4.4	1.3	6.3	4.7	4.9	5.0	7.0	3.0	7.0	3.7	5.4	4.4	5.0
practical help ideal	5.3	3.0	7.0	6.2	1.3	6.3	4.7	5.1	1.0	4.0	4.3	7.0	4.6	4.6	5.3	4.7
practical help discrepancy	0.0	1.7	0.7	1.8	0.0	0.0	0.0	0.3	-4.0	-3.0	1.3	0.0	0.8	-0.8	0.7	0.0
social time actual	4.8	5.0	5.0	7.0	3.0	6.0	4.7	3.9	4.3	4.0	3.5	7.0	5.0	4.8	5.0	4.3
social time ideal	4.3	6.0	4.3	7.0	4.3	6.0	4.7	3.9	5.3	4.0	3.5	7.0	5.2	4.9	4.3	4.7
social time discrepancy	-0.5	1.0	-0.7	0.0	1.3	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.2	0.1	0.0	0.0
RSQ secure	3.4	5.2	3.8	4.0	3.0	4.0	4.2	5.0	2.8	3.4	3.8	4.2	3.9	3.9	3.8	4.0
RSQ fearful	4.5	4.0	4.0	5.5	6.5	3.8	2.0	2.8	7.0	4.5	6.3	4.8	4.9	4.4	4.5	4.5
RSQ preoccupied	3.0	5.0	4.5	5.5	3.8	2.8	4.3	3.0	2.5	5.0	3.5	4.0	4.4	3.6	4.5	3.5
RSQ dismissing	3.8	3.0	5.0	4.8	6.0	5.2	4.2	4.0	7.0	5.8	5.2	4.4	4.5	5.1	4.8	5.2
PBIQ control over illness	10.0	10.0	11.5	13.0	11.0	13.0	9.0	10.0	10.0	13.0	10.5	7.0	11.1	10.4	11.0	10.0
PBIQ self as illness	11.0	8.0	10.5	9.0	12.0	10.0	8.0	9.5	14.0	8.0	11.0	10.0	10.1	10.1	10.5	10.0
PBIQ expectations	7.5	5.0	7.5	5.0	6.5	9.0	8.0	9.5	8.0	10.0	6.5	5.0	6.3	8.0	6.5	8.0
PBIQ stigma	6.0	5.0	7.5	10.0	8.0	7.0	5.0	6.0	9.0	7.0	7.5	5.0	7.3	6.6	7.5	7.0
PBIQ social containment	5.0	4.0	8.0	4.0	3.0	4.0	4.0	4.0	5.0	5.0	3.5	4.0	4.8	4.2	4.0	4.0

Figure 3.2: Sample of chart and table comparing qualitative-quantitative data.

In accordance with Glaser and Strauss' (1967) aforementioned 'meaningful relaxation', both the definition of 'significant contributor' and the magnitude of 'significant difference' were judged subjectively. This process was conducted for every combination of constructed category (N=30) and quantitative subscale (N= 28) totalling 840 comparisons. These comparisons informed the literature search in a reciprocal manner. Where 'clusters' of differences were observed the

researcher was prompted to examine the literature for connections between the relevant concepts. For example, ratings of subscales of the RSQ were found to differ between significant and non-significant contributors to 'problem patterns' categories, suggesting that problem patterns may be interpretable within an attachment framework. A review of the literature concerning attachment and mental health supported this, and comparisons with prior findings are discussed. Conversely where prior knowledge of the literature predicted a relationship, for example one might anticipate a connection between the categories within 'making sense of illness' and ratings on the PBIQ, comparisons were closely examined and discussed with regard to their correspondence (or otherwise) with prior findings. Many comparisons yielded no significant difference (or absence of difference) which was interpretable in the context of extant literature, consequently only a small proportion of the total comparisons are presented in the results.

Chapter 4: Findings.

The central theme of participants' narratives is *facing choices*. Patients face choices throughout the illness experience, but the nature of these choices, participants' perception of them, and their strategies of approach vary. The analysis generated 14 themes, with 22 subthemes. These are described and discussed in broadly the sequence that they typically arose in participants' narratives, though I emphasise that the progression is not strictly linear and that some themes are salient throughout the inpatient experience. A series of schematic diagrams illustrates the relationships between the themes under discussion[5].

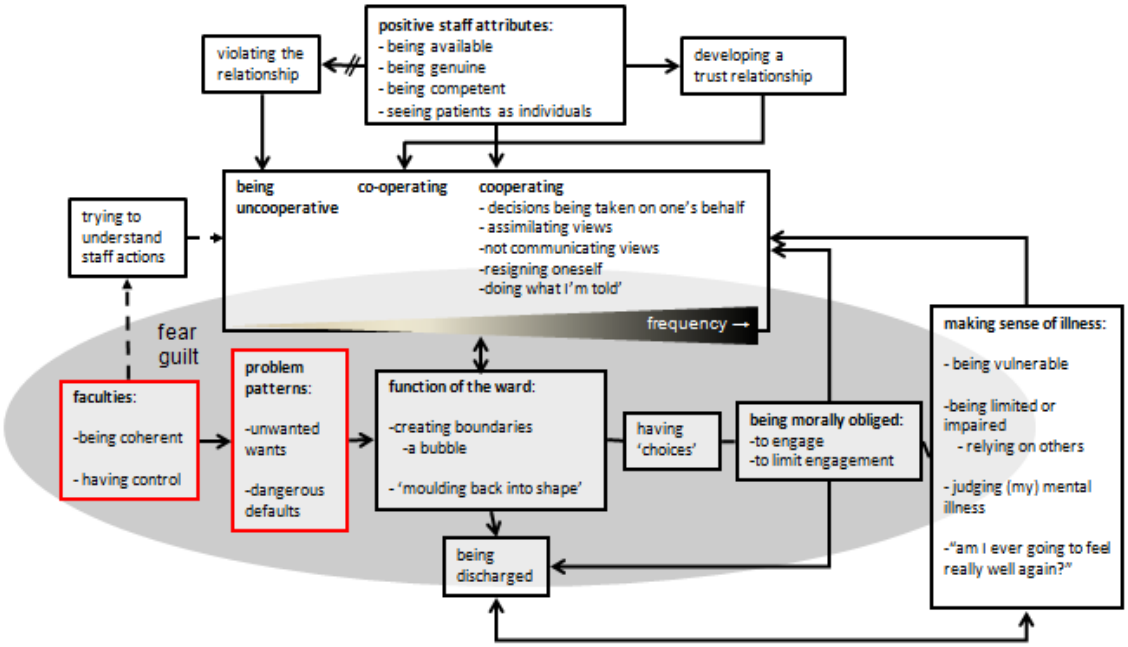


Figure 4.1: Facing choices, faculties and problem patterns.

The themes *being coherent* and *having control* were constructed from participants' accounts of early awareness of acute mental illness. Coherence, as a theme, refers to one's perceived capacity to think clearly and make reasoned choices. In their illness participants describe experiences of 'turmoil', 'madness' and 'hysteria' which obstruct their ability to do so. They lose concentration, their thoughts race, they have thoughts which they later recognise to be

[5] Note that *italicised* phrases in the text indicate category titles.

delusional. They are unable to maintain a sense of proportion or perspective, or to recall and thus be guided by past experiences. Some are aware of a gradual deterioration while for others, like Brian whose 'thoughts just went all haywire, just eh, almost in a oner', the very rapidity of onset contributes to the resulting distress. The experience can be so alien that it amounts to a loss of sense of self. Fiona, a young woman describing her first experience of mental ill health said 'I was starting to feel a bit... mad in myself. I wasn't feeling like me any more'. In contrast for Gillian, who has a twenty year history of schizophrenia, the deterioration is only an exaggeration of 'normal' experience. She is seldom able to control her attention, and is constantly at the mercy of intrusive stimuli. At its worst Gillian experiences this as a total absence of structure:

> I find it hard to be a person. And I disintegrate. ... It's got quieter in here, so I've managed to come back in, whereas when it was noisy before I felt my whole personality, my whole being was shattering into pieces, and not being able to cope with it. Losing control. Disintegrating.

Control is the ability 'to exercise restraint or direction' ('control', 2011) over one's own thoughts or actions, to implement choices. As a theme it refers to the ability to resist urges, or to maintain functional behaviour. Coherence is necessary but not sufficient for control: 'I'd make plans the night before then when it came to the time to do it I I just couldnae do it' (Colin). Lapses or losses of control in the period prior to admission included aggressive outbursts, excessive spending, poor self-care and substance misuse (which further lessens control). Losses of control were typically described as 'spiralling' or 'snowballing' over time, despite awareness and effortful resistance. Angela described a different perception though; her self-harm is 'sort of a knee jerk reaction', beyond any control.

Subsequent to diminished coherence and control, participants describe two distinct *problem patterns*; unwanted wants and dangerous defaults. These can be understood as maladaptive 'acts' of commission and omission respectively. The theme of *unwanted wants* includes conceived, anticipated, planned or completed actions which would be objectionable to participants when they are well. These are primarily suicidal urges and acts of self-harm, but also intense over-activity, impulsive and grandiose or reckless plans and behaviour. Unwanted

wants can be transient or persistent. Participants expressed having two or more opposing desires simultaneously or sequentially, for example to die and to be kept safe. Jack described this as 'two alter egos...fighting with each other'. This can lead to apparently chaotic or contradictory behaviour, such as overdose followed by help-seeking. Unwanted wants are not always ego-dystonic: Gillian enjoys the energy and exhilaration that the manic state entails. Negative perceptions come later, when one realises the consequences of one's actions.

The theme of *dangerous defaults* represents acts of omission, failures to carry out necessary acts to maintain good functioning, e.g. Derek's failure to properly manage the diet and medication which are essential to his physical and mental health. The defining feature is the sense that one's natural inclinations or tendencies are a threat to one's own or others' wellbeing, and that one must therefore avoid a 'slippery slope'. Substance abuse represents a blending of unwanted wants and dangerous defaults. For example when Ellen gives in to unwanted wants (alcohol) she slips back into an unhelpful pattern of social withdrawal and self-harm.

Participants' descriptions of emotional volatility, confusion, intrusion and loss of sense of self in these themes, suggest they are experiencing impaired mentalisation. Mentalisation is the process of adaptively attending to and responding to mental states – perceptions, cognitions, emotions, motivation etc. – in oneself and others. It is crucial in interpreting social interactions and distinguishing internal experiences from 'reality' (Allen *et al.,* 2008). Mentalisation 'underlies the capacities for affect regulation, impulse control, self-monitoring and the experience of self-agency – the building blocks of the organisation of the self' (Fonagy *et al*., 2005, p.25), thus lower 'levels' of mentalisation are characterised by poorly contained and expressed emotions, and inappropriate impulses (Allen *et al.,* 2008). Impaired mentalisation has been conceptually linked with disordered eating (Skarderud, 2007), self-harm (Yates, 2004) and substance abuse (Jurist & Meehan, 2009). Though most research into mentalising in adults has been conducted with participants with diagnoses of borderline personality disorder or schizophrenia, Fonagy *et al.* (2011) recently characterised it as a 'transdiagnostic concept' (p.101) and similarities of accounts between participants with diverse reasons for admission in this project support this assertion.

Mentalisation is grounded in attachment theory. Theoretically, securely attached adults will have internal working models of themselves and others as valued, autonomous beings, and their interpersonal narratives will be marked by sensitive, balanced and flexible mentalisations. Insecurely attached individuals will lack such positive models and their mentalisations will comprise superficial preoccupation with negative attachment experiences (anxious attachment) or denial and denigration of emotional needs and experiences (avoidant attachment; Lopez, 2009). Where mentalisation has been operationalised as reflective functioning (Fonagy *et al*., 1998) this hypothesised relationship between insecure attachment style and reduced reflective functioning has been empirically demonstrated (e.g. Bouchard *et al.,* 2008; Macbeth *et al.,* 2011).

Reflective functioning is assessed by evaluating the quality of interviewees' narrative in response to questions from the Adult Attachment Interview (AAI; Main & Goldwyn, 1998). I am not appropriately trained, nor were the appropriate topics addressed in these interviews, so no formal evaluation of the reflective functioning of participants in this project will be attempted. Nonetheless some brief comments may be informative. There was substantial variation between participants in terms of the quality of narratives. While some participants spontaneously offered a complex, reflective narrative, there was indication that others were unwilling or unable to reflect in detail on their recent experiences. Though none directly declined to answer a question, some employed strategies to divert attention from internal events. Jack for example spoke at great length about his emotions, but in an intellectualised manner, using medical/psychological terminology and repeatedly moving from describing his own experiences to referencing a book I had recommended. Subject changes were common; Derek repeatedly drew attention to his past achievements, while Brian repeatedly praised staff. In extreme cases, Ellen and Ken, whose interviews were short and coded sparsely, responded to many questions – open and closed – with 'I don't know' or silence. Laithwaite and Gumley noted similar narrative limitations in their interview study of forensic inpatients (2007).

There was also within participant variation: in general the second interview generated richer, more reflective data than the first. It is not possible to attribute this conclusively to recovering reflective function, as there is the potential confound of increased interviewer familiarity.

Similarly it is impossible within this study design to differentiate between possible explanations for narrative limitations. State impaired mentalisation at the time of acute illness may mean memory of the period is inhibited: 'I can't honestly remember' (Isla) was a common response to the opening question 'How did you come to be in Huntlyburn?' Alternatively state impaired mentalisation at the time of interview, or trait impairment of mentalisation, may be limiting narratives. As a result the following relationships, though supporting the hypothesised link between attachment insecurity and impaired mentalisation, should be interpreted cautiously.

Standardised assessments support a link between attachment styles and impaired mentalisation as inferred from these themes. Significant contributors to coherence, control and unwanted wants also rated themselves more highly for fearful attachment (indicating high levels of attachment anxiety and avoidance). Significant contributors to dangerous defaults, rated themselves more highly for dismissing attachment (high avoidance), and it is intuitively sensible that a tendency to deny one's mental state may facilitate descent down a 'slippery slope'. Significant contributors to all four themes also rated their actual and ideal access to social support as lower, suggesting less inclination to turn to others in times of distress, a characteristic which has also been linked to insecure attachment style (e.g. Vogel & Wei, 2005).

The findings of this project also illustrate ongoing discussion about mentalisation as trait versus state (e.g. Fonagy & Luyten, 2009). It was originally supposed that an available, responsive care-giver who closely 'mirrored' an infant's mental state would both function as a 'safe haven', promoting secure attachment and allow the infant to observe and differentiate his own and the care-giver's mental states, promoting mentalisation (Fonagy *et al*., 2005). Under this model secure attachment would be associated with apt mentalisation and insecure attachment with globally impaired mentalisation: the trait model. There is some evidence for this in the empirical literature (see Fonagy *et al.,* 2005 for a review) and in this project: significant contributors to these themes were more likely to agree with PBIQ 'self as illness' statements indicating that problem patterns were an inherent aspect of self.

More recent research though suggests that capacity to mentalise varies with arousal level (e.g. Arnsten, 1998) and that brain areas associated with attachment and mentalisation functions may

in fact be mutually inhibitory (Fonagy & Luyten, 2009). It is now suggested that secure attachment in infancy leads to reduced need to implement attachment strategies – such as amplifying (anxious) or minimising (avoidant) distress - and more opportunity to practice mentalisation. However the *potential* for threat to activate attachment strategies remains (Fonagy, 2006). In adults this results in a predominantly mentalising stance, with recourse to 'developmentally antecedent' strategies only in extreme distress: the state model. Since securely attached adults will perceive fewer threats and have more constructive coping strategies (Mikulincer & Shaver, 2007) this state will arise more often in insecurely attached adults. Support for the state model in this project is seen in the narrative accounts: almost all participants identified an interpersonal stressor as the initiator of the current episode of impairment, however all participants also referenced past periods of improved reflective functioning.

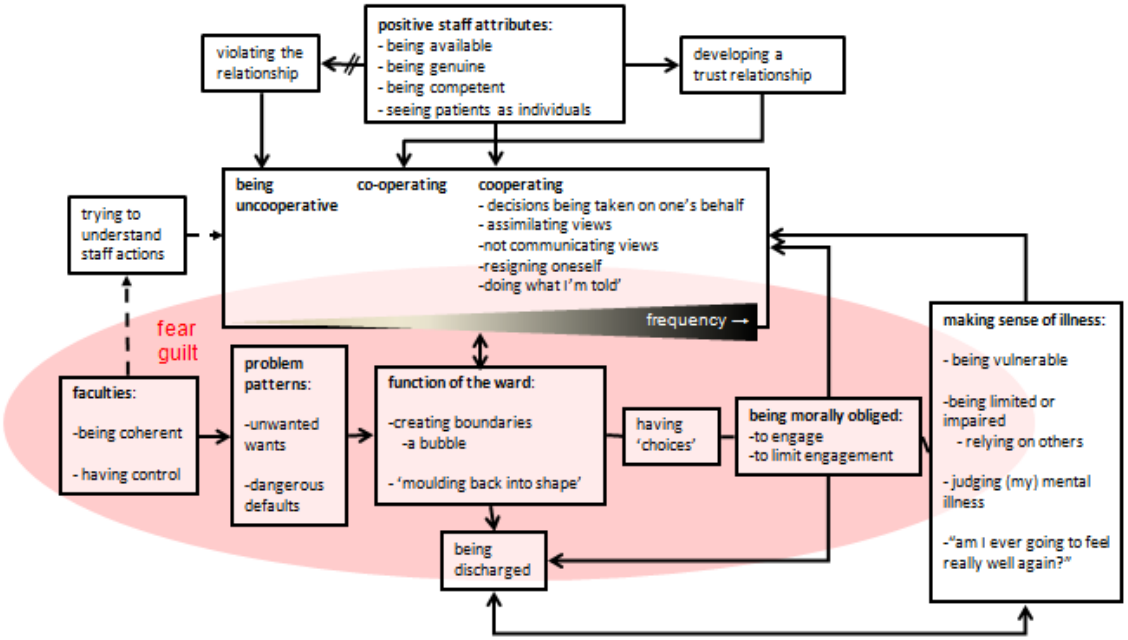


Figure 4.2: Facing choices, fear and guilt.

Perceiving their own mental states and actions as potentially harmful, participants describe *fear* and *guilt*. Significant contributors to the themes of fear and guilt scored more highly on HADS anxiety and depression subscales. Significant contributors to fear rate themselves more highly for fearful attachment, reported lower levels of actual and ideal social support, and were more

likely to endorse PBIQ statements about control over illness and perception of stigma. Participants reporting more guilt conversely indicated higher levels of social support, but were more likely to agree with PBIQ statements about expectations, such as 'I am capable of very little as a result of my illness' (Birchwood *et al*., 1993, p.394).

It is possible to draw succinct theoretical inferences from these findings; participants who reported insecure-fearful attachments are both more likely to describe impaired affect and impulse regulation and less able to access social support, placing them at greater risk and thus rendering them more anxious. Or, participants who consider themselves to be lifelong dependents will seek and receive more social support but are likely to experience guilt for doing so.

However, participants' accounts do not support the interpretation of fear or guilt as cause or effect in a linear narrative in this way. Rather they are a pervasive feature of participant experience, and function as *both* cause and consequence of events during this period. Participants are frightened *of* their problem patterns and their potential consequences; *of* being admitted to Huntlyburn; *of* the return of their symptoms; *of* social judgement. But they are also frightened *into* help-seeking; *into* engaging with treatments; *into* altering their lifestyles to avert relapse. Similarly guilt was described as a consequence of one's observed impact on others, and of perceived condemnatory judgements by self and/or others, but was also a cause of treatment engagement and sometimes disengagement. Fear and guilt were described by participants as initiating their difficulties, and also as a symptom of them. For example, while Jack observed that his suicidal thoughts were prompted by guilt – the perception of himself as a failure and a burden – Derek understands guilt to be a manifestation of his illness:

> ...when you come in here and, you know... after a couple of days you start to feel that guilt complex, you say oh godalmighty I feel really guilty, I'm, there's a lot of people in here worse off than me. [##R## Right.] You know there's a lot of people in here that need more help than me, and [##R## Mmm Hmm.] You know the nurses are bombing about the place trying to look after everybody and eh... This, that I said to = *consultant psychiatrist* = I said this, he said to me this guilt that you have is a sign of depression.

Throughout the illness experience people's choices are restricted or directed by their emotional state. For this reason fear and guilt are represented in the schematic diagram as underlying conditions rather than stages.

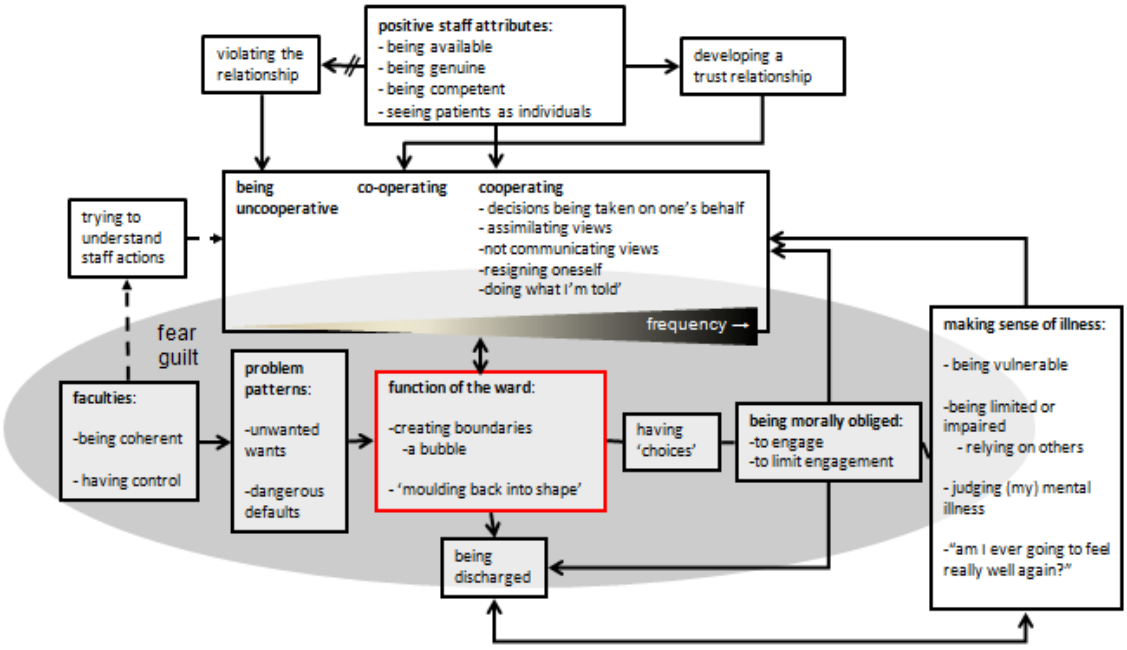


Figure 4.3: Facing choices, the function of the ward.

Eight of the twelve participants were admitted as a direct result of urges or attempts to self-harm (unwanted wants). Four were admitted due to continuing deterioration in functioning (dangerous defaults). In these circumstances the *function of the ward* is to restrict choice. The ward serves as a safety net - it *will not let you* do what you 'want' to do, it *will not let you* slip too far down your slippery slope.

Huntlyburn does this by *creating boundaries*. There is limited access to implements or substances to abuse, indeed one can be issued with 'chemical restraints' such as Antabuse. The availability and vigilance of staff limits erratic behaviour, and is containing in times of extreme distress. Boundaries appear to function by strengthening one 'side' of ambivalence, rather than by actual restraint. For example Angela finds being reminded that she will have to leave Huntlyburn if she self-harms helps her to resist, even though part of her wishes to leave the ward

to self-harm. The perception of the *ward as a bubble* is a special instance of creating boundaries. In this case the boundaries are not between the person and their own (in)actions, but between the person and external stressors. Huntlyburn allows Fiona 'a rest' from too-heavy responsibilities, it allows Linda 'space' to grieve for her daughter.

Through diminished coherence and control, participants feel incapable of creating and enforcing such boundaries themselves. Their narratives make reference to when they have tried to do so and failed, to past suicide attempts or 'breakdowns'. Their unwanted wants are catastrophised and seeking the boundaries of the ward is reinforced as a safety behaviour:

> If that doctor hadn't admitted me to Huntlyburn, I I think I would have took one [an overdose]. If I hadn't of got in. (Henry)

Huntlyburn also functions by *moulding you back into shape*, a phrase coined by Derek. There are therapeutic interventions, both pharmacological and psychosocial. There is nurturing, concern and 'coaching' from staff and from fellow patients. The ward routine promotes more adaptive functioning in terms of self-care, diet and sleep hygiene, and this small start to self-efficacy can become self-sustaining. This process may be comparable to Sbarra and Hazan's (2008) account of the development from co-regulation to self-regulation, which takes place in the context of an attachment relationship.

Expectations of what the ward can offer in terms of 'moulding' are not always met. Fiona expected practical support in rebuilding family relationships, Jack expected intense psychotherapy. Both revised their expectation as 'naive', though in fact they were not unusual: Fleischmann (2003) found that more than ¾ of inpatients interviewed prior to admission anticipated talking therapy, and more than ⅓ expected formal psychotherapy. Participants who expressed very high expectations indicated greater dissatisfaction with their social support but lower expectations of lifelong dependence on services or need for social containment on PBIQ scales. These participants may be seeking brief but intensive support from the ward in its absence elsewhere.

These conceptualisations of the function of admission are closely aligned with others in the literature. Thomas *et al.* (2002) in a phenomenological interview study, found "the essential meaning of the ward for psychiatric patients was a refuge from self-destructiveness" (p.101) and respite from external stressors. Hummelvoll and Severinsson (2001) in an observational study found that the principal needs of inpatients were security, sleep and respite, and meaning making – being set on 'a new track' (p.21). From a service perspective, Chiovitti's (2011) grounded theory of psychiatric nurses' understanding of caring on the ward identified 'keeping the patient safe' and 'encouraging the patients' health' as main themes of 'protective empowering'. Bowers *et al.* (2009), synthesising qualitative and quantitative research and policy documents, generated a model of acute inpatient psychiatry. The themes of 'containing'; the redefining and enforcement of boundaries between self and others and self and objects, and 'presence+'; the availability of benevolent support to attain/regain functioning, are analogous to creating boundaries and moulding back into shape respectively.

In the Bowers *et al.* (2009) model, availability of social support serves as a 'filter' determining whether patients are admitted. Significant contributors to the themes of creating boundaries and ward as a bubble indicated they had lower levels of social support and were less satisfied with these. This trend was less marked for significant contributors to the theme of moulding back into shape. Given the recurring theme of containment and external regulation of affect and actions, there are notably few relationships between the functions of the ward and attachment subscales. Significant contributors to the creating boundaries theme scored more highly on fearful and dismissing subscales, both indicating high attachment avoidance. This may be in keeping with a crisis response which seeks to put boundaries between self and stressors. However, no relationships are seen between attachment and the themes of ward as a bubble or moulding back into shape. That is, those participants whose accounts contributed to these themes scored no differently on attachment subscales than those whose accounts did not. Participants seeking both boundaries and a moulding influence from the ward were more likely to endorse PBIQ statements indicating lack of personal control over illness, which might be consistent with seeking external control, but there were no other consistent trends in illness appraisal. It may be that the finding that the functions of admission as observed in this project are so closely aligned

to those in existing studies can explain this: if what patients seek from inpatient care is universal, there is no reason to hypothesise between-group differences.

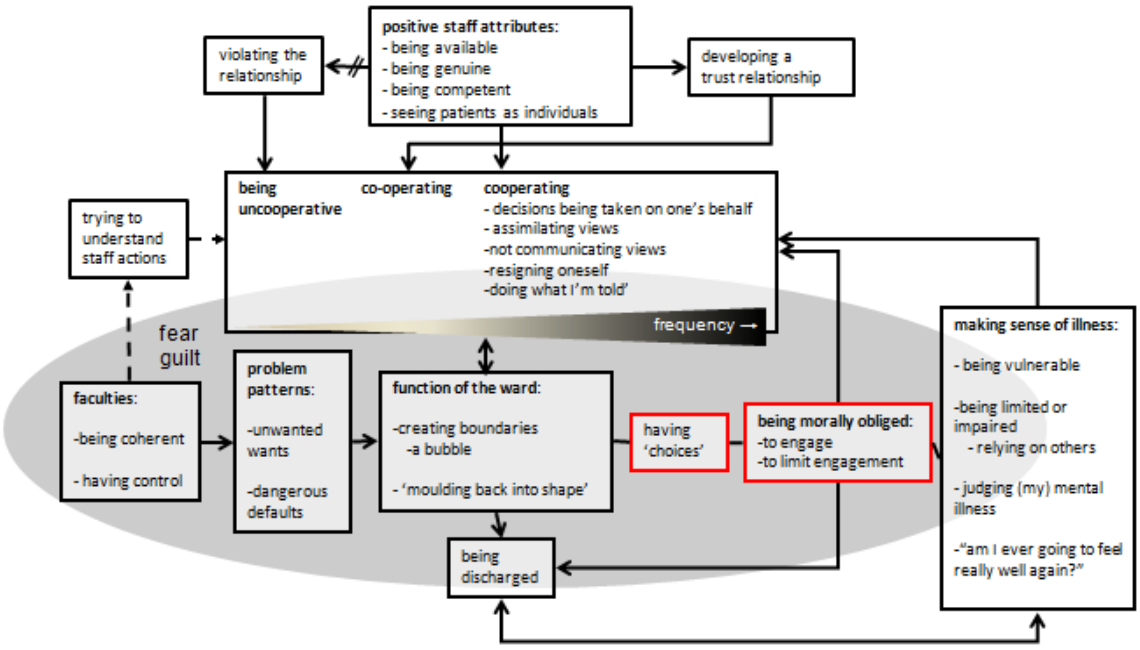


Figure 4.4: Facing choices, moral obligations.

Though the ward is protectively restrictive, participants do still *have choices* during admission, including whether and when to enter and leave Huntlyburn and the extent of engagement in ward activities. Choices are highly valued, particularly by participants who have historically experienced restrictive or aversive treatments, or where the multiple losses of chronic illness mean exercising residual control is of paramount importance. However, there is a distinction between being presented with options and feeling like one has meaningful choices. For example, though all participants were 'voluntary' admissions, *all* stated they were admitted not by choice, but by necessity - choice is restricted by fear:

> ...anyone who understands my care plan knows hospital for me is the last resort. I hate going to hospital. [##R## Mmm hmm.] I only go to hospital if it's life or death. (Henry)

> I think I was very frightened, em, about going into a psychiatric unit. Em, but I was probably more frightened about, not. (Jack)

Conversely, some incidents are regarded as being offered choices though it is not clear that this is the case. Gillian and Ken, both of whom had previously been detained, were asked 'do you think you should be in hospital?' They said yes, and were pleased to have been asked. I can only speculate as to the outcome had they said no. In Henry's case this 'non'-choice was very explicit:

> I said 'Well you can't section me' and she said 'Oh yes I can'. So I went, they were in here a long time, and basically were saying, if you don't come to hospital, we will take you there. [##R## Right.] The GP will section me, for twenty four hours. Something like that, I don't know what it is, eh, what the law is. But she said she could get me to hospital. [##R## Right.] So I agreed to go in voluntary.

Much has been written about the value of choice and its integral role in a recovery approach (e.g. Bonney & Stickler, 2008). We see in these accounts though that the relationship between alternatives and choices is not straightforward. A further constraint on patient choices is their perceived moral obligation to choose in accordance with what is 'right'. Seven participants made reference to *being morally obliged to engage* with treatment, giving reasons that fell into three broad themes; reciprocity - if staff offer help you should meet them halfway; personal responsibility - you should be involved in your own recovery; wasted opportunities - you should try anything and everything that might help. Linda captured two of these:

> I suppose I'm, I'm of the frame of mind, when they, you're in the hospital and people are there helping you, encouraging you to be able to take part in life again. You have to be equally, as grateful, and make every effort that they're doing to help you, you have to make that effort to help yourself.

Eight participants made reference to *being morally obliged to limit engagement*, for example minimising help-seeking by 'phone. Reasons given again fell into three themes; there are others in greater need (especially those who have a 'proper' illness, one which they have not 'brought upon themselves'); staff resources are scarce - once you have had 'enough' you should move on; personal responsibility – to hide in the 'cocoon' of the ward is to avoid 'real life' eventually you must emerge.

There are few but pertinent discussions of the moral obligations of patients in psychiatric settings in the literature. Colombo *et al.* (2003) summarised six implicit models of mental health held by patients, professionals and carers (medical, social, cognitive-behavioural, psychotherapeutic, family interaction and conspiratorial). All but one proposes that the 'duties of the patient' are to cooperate with treatment, though the nature of treatment may vary. Parsons' (1978) classic conceptualisation of the sick role is also relevant. Parsons proposed that 'sickness' is a medically sanctioned form of social deviance. The 'sick' are exempted from blame for their and condition from normal social responsibilities. In return, they are obliged to define their sickness as undesirable and seek and adhere to professional advice to get 'better'. There are clear parallels both with moral obligations and with the functions of the ward. Interestingly, significant contributors to the moral obligations themes score lower on the scale of self as illness. Parsons' model has been criticised for its limited applicability in chronic illness (e.g. Furedi, 2004). It seems that those participants who reference aspects of Parsons' model are also those who view their experience as a temporary aberration rather than an enduring condition.

The sick role was grounded in psychoanalysis, and Parsons viewed the professional/patient relationship as quasi-parental (1978). It is therefore notable that there were no relationships between attachment subscales and these themes. Significant contributors to moral obligations did give lower ratings of both depression and anxiety, and there are a number of plausible, sick-role consistent explanations for this, for example those with higher psychopathology are still 'too sick' to be under obligation, or those who met their obligations to engage are consequently 'getting better'. It is not discernible from the interview data which if any are operating.

There is an important contradiction between Parson's sick role and the findings of this study: many participants *do* perceive themselves as to blame for their illness. Consequently their inability to meet normal responsibilities is accompanied by feelings of inadequacy not relief, and their moral obligations to engage are driven by guilt and shame rather than a positive pursuit of wellness. A growing number of studies using the PBIQ or similar measures suggest that shame, humiliation and reduced social status are prevalent perceptions among people experiencing mental illness, particularly those experiencing psychosis (Birchwood *et al.,* 2000; Iqbal *et al.*,

2000). In a grounded theory study of overcoming shame van Vliet (2010) highlighted links between the experience of shame and perceptions of control: in a shaming situation one is to blame for the problem, but not in control of the solution. Significant contributors to moral obligations themes indicated lower perceived control over illness on the PBIQ.

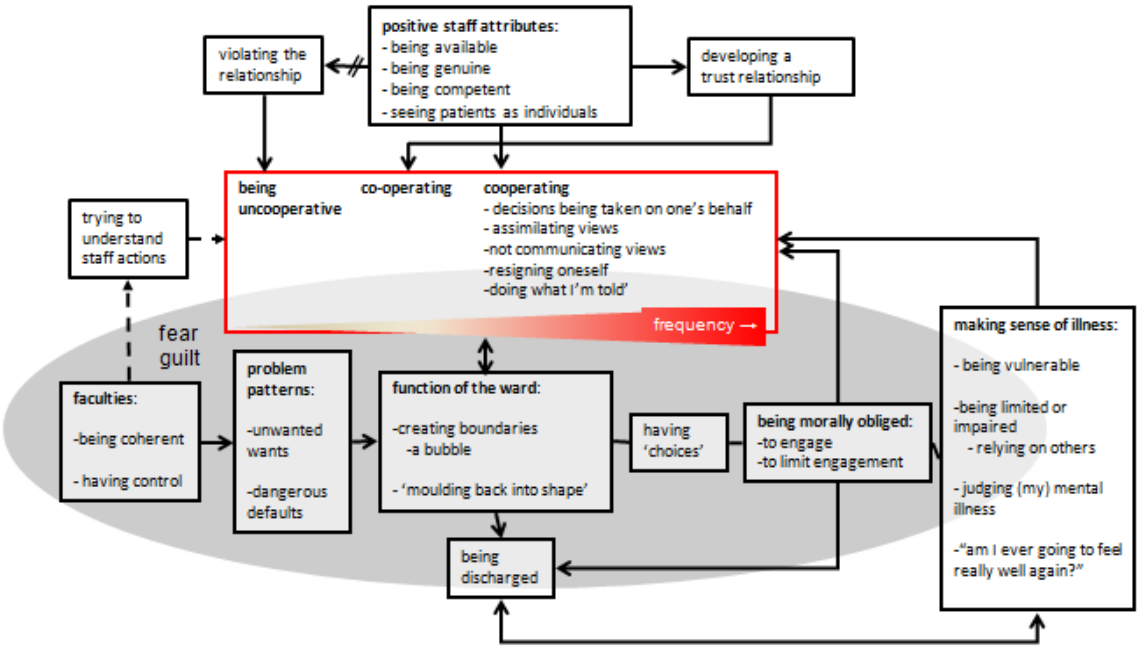


Figure 4.5: Facing choices, engagement strategies.

Patients' understanding of the choices available to them and their ability to effectively implement choices, are manifested in patterns of interaction with others. Three themes were constructed to represent participant accounts of engaging with staff; *co-operating*, in the sense of working jointly to the same end; *cooperating*, in the sense of being compliant; and *being uncooperative*. These can be regarded as continuous, with the majority of described incidents occurring at the cooperative end of the spectrum. Co-operating takes place where patient and staff views are both openly available and respected, such that choices are informed by – if not perfectly suited to – both parties. It may take the form of expressing needs or wants, inviting or pursuing particular treatments, negotiating passes or discharge, or attending ward rounds or review meetings. Co-operation is most effective where patients feel 'coached' not 'dragged' or manipulated.

Cooperating describes acquiescing to suggestions or expectations while offering little input. Patients cooperate – or profess an intention to cooperate - with treatment plans, suggested coping strategies and proposed lifestyle changes. Cooperation has previously been noted as a deceptive strategy to attain earlier discharge (Hummelvoll & Severinsson, 2001; Sayre, 2000) but this was not the case in this project. Rather, cooperation is driven by fear, hope and not knowing what else to do. Feeling a moral obligation to engage is also associated with cooperative interaction patterns, the one being effectively the behavioural manifestation of the other.

Several distinct strategies of cooperative interaction were observed. Participants, even Brian who spoke enthusiastically about collaborative decision making in his working life, allow *decisions to be made on their behalf*. In some instances this is a pre-emptive strategy: Henry decided while well to grant his sister financial power of attorney in order to limit the damage wrought by his characteristic problem patterns. Having allowed decisions to be made, participants describe *assimilating the views* of the decision-maker. One has a sense that this serves to reduce dissonance where an undesired event has been presented as a fait accompli:

> Em, so she [consultant psychiatrist] didn't think that being in any longer would help anything anyway, so...
>
> ##R##
> What's your view on that?
>
> I think she's right. Em, I still didn't want to leave but... [##R## Alright.] I think, I don't think they could have done any more for me in there" (Fiona)

Most participants cooperate because they agree with (or have assimilated) staff views, or because they hold no strong personal views. Apathy was repeatedly identified as an aspect of diminished coherence. Participants made comments such as:

> Being in Huntlyburn, it didn't mean anything, it's just a place. You're so preoccupied with your own thoughts and mind [##R## Right.] that you didn't notice where you were. (Gillian)

Guess *et al.* (2008) described choice as an expression of autonomy and dignity and a universal entitlement. However they also identified the prerequisites of choice as a say, options and a *preference*. Some participants were unable, as a result of acute illness, to identify preferences. This is not unusual: Fleischmann (2003) found that 1 in 5 people at admission to inpatient care were satisfied to leave treatment decisions to their doctor.

Some participants however, hold opposing views but elect *not to communicate* these. One reason is a sense of futility. Fiona did not press her concerns (above) because 'I think that if I had said "I don't want to leave" I think I still would have had to leave'. The more common reason is conflict avoidance, participants fear causing discord when their distress tolerance and sense of interpersonal control is so fragile. Closely linked to not communicating views is *resigning oneself* to circumstances. This can be a positive process of letting go of anger and frustration: Angela refers to her 'radical acceptance' strategy acquired in DBT. However resignation can also be an angry and frustrated act. Birchwood *et al.* (1993) drew a similar distinction between acceptance of a diagnosis of mental illness as a passive conforming or active integrating act.

In general cooperation is considered a successful approach, though not always: Brian conscientiously attended a daily group that he found to be completely useless. Brian and Colin though are participants for whom '*doing what I'm told*' has gained an almost talismanic property. Their cooperation on the ward has coincided with their recovery, and they now hope to avert relapse by taking advice 'as read':

> I've come to eh the, ken before I wouldnae do everything I was telt. But now I do everything I'm telt. [##R## Right.] I do everything I'm telt. If they tell me to do something like ye ken. If = *CPN* = told me to jump in the Tweed I'd do it. (Colin)

For most patients though, engagement with staff is not so uncomplicated. There is increasing literature linking attachment theory to engagement and treatment choices throughout the illness trajectory (e.g. Hunter & Maunder, 2001; Ma, 2007). Dozier (1990) found that secure attachment was associated with better attendance and medication adherence, while avoidant

attachment was associated with less help-seeking, less self-disclosure and poorer treatment use (though note that outcomes were clinician rated and therefore might reflect the unpopularity of avoidant patients – see Adshead, 1998 – rather than objective appraisal). Attachment avoidance has been associated with poorer ratings of therapeutic alliance by patients and staff (e.g. Berry *et al.,* 2008) and Tait *et al.* (2004) found that insecure attachment style was associated with greater likelihood of disengaging from services following an episode of psychosis.

One hypothesised basis for these findings is internal working models of care-givers (e.g. Ma, 2007). Secure individuals have positive models of self and others, they can disclose needs without feeling vulnerable and collaboratively engage with others, whom they perceive as reliably able to meet them. Dismissing individuals have a 'defensively positive' (Wei *et al.* 2005) model of self, and negative models of others as incapable of meeting needs. They deny needs and reject support. Anxious individuals conversely have negative models of self, thus high needs, and positive models of others' capacity to meet them. They freely communicate needs, and constantly seek support. Fearful individuals have negative models of both self and other, their needs are high but they do not perceive others as able to meet them. They exhibit a chaotic approach-avoid pattern (Hunter & Maunder, 2001; Dozier & Bates, 2004). Standardised assessments – to a limited extent – support a link between attachment and engagement themes consistent with this interpretation. Significant contributors to co-operation had lower scores for fearful attachment, and marginally lower scores for preoccupied and dismissing styles. Significant contributors to cooperation, the general theme reflecting acquiescence to suggestions – with an implication that suggestor and suggestee are capable - had higher scores for secure and lower scores for fearful, preoccupied and dismissing styles, exactly as might be expected. However there were no consistent relationships with attachment at the level of individual cooperative strategies. Scores on the PBIQ expectations subscale which includes statements such as 'I will always need to be cared for by professional staff' were higher among significant contributors to co-operative and cooperative engagement. This may be consistent with a negative model of self and/or a positive model of staff as able to meet one's needs.

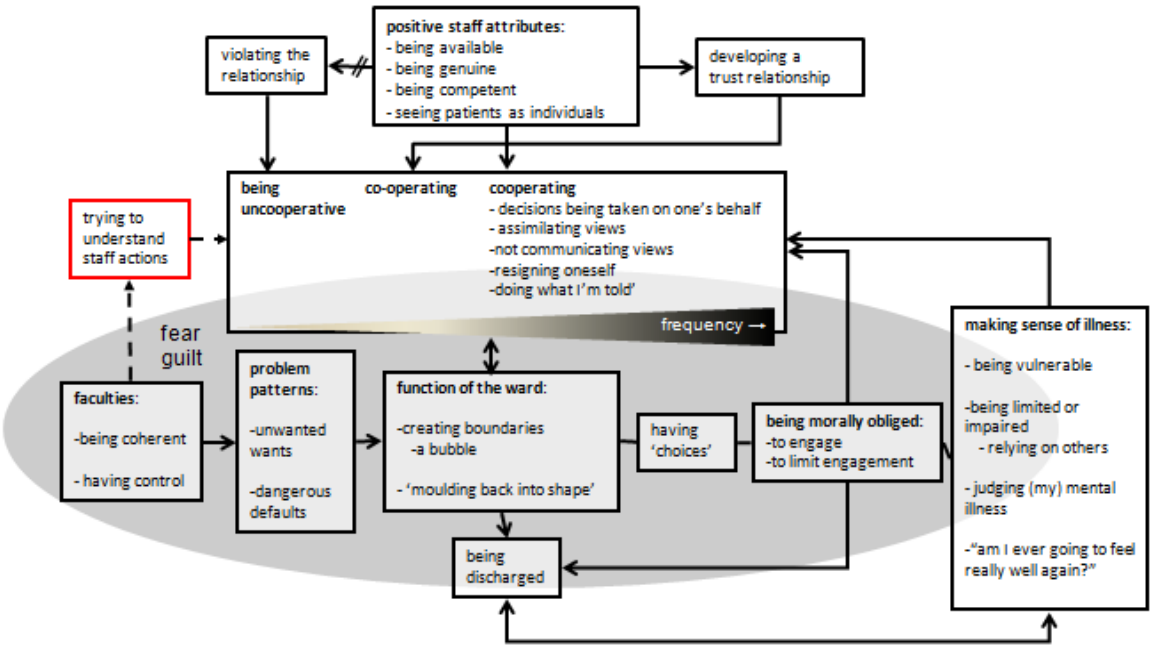


Figure 4.6: Facing choices, trying to understand staff actions.

The theme *trying to understand staff actions* suggests an alternative means of linking engagement patterns to attachment concepts: via mentalisation. All but two participants made explicit reference to trying to comprehend the reasoning underlying decisions, though Jack gave the most explicit description:

> You know you evaluate; what choices do I have? [##R## Mmm.] Em, what expertise does this person have? You know what knowledge do they have? Why am I going to follow this person em, into that situation? And if, you know, I suppose if you feel that that they know what they're talking about and [##R## Mmm hmm.] and it's not, an an order but it's a, you know it's a strong suggestion then yeah, I'm quite comfortable following people.

This clearly indicates approaching choices by 'weighing up' and comparing personal views to those of staff. To do so necessitates reasonably sophisticated mentalisation; internally representing qualities, intentions and motives of self and other. It is likely that this is much more challenging at times when mentalisation is impaired, such as the acute phase of illness. Note that the above excerpt was drawn from Jack's second interview. In his initial interview he had described acquiescing to a psychiatrist's suggestion because she was 'very pleasant', a less

sophisticated evaluation. Significant contributors to the theme of trying to understand staff actions, i.e. those most explicitly reporting mentalisation, scored slightly higher on the secure subscale of the RSQ, and lower on insecure attachment subscales, particularly the dismissing style.

Participants were clear that co-operation and cooperation are facilitated where there is a plain rationale for the course of action, echoing the finding of Johannson and Eklund (2004) that programme clarity is a significant predictor of helping alliance. I suggest that this is because impaired mentalisation means patients struggle to comprehend staff actions and decisions without explicit justification, in which circumstance they are more likely to make oversimplified, negatively biased interpretations ('they're paid to keep people out of hospital'; Henry); and to be uncooperative or withdraw from contact as previously referenced (e.g. Dozier, 1990; Tait *et al.*, 2004).

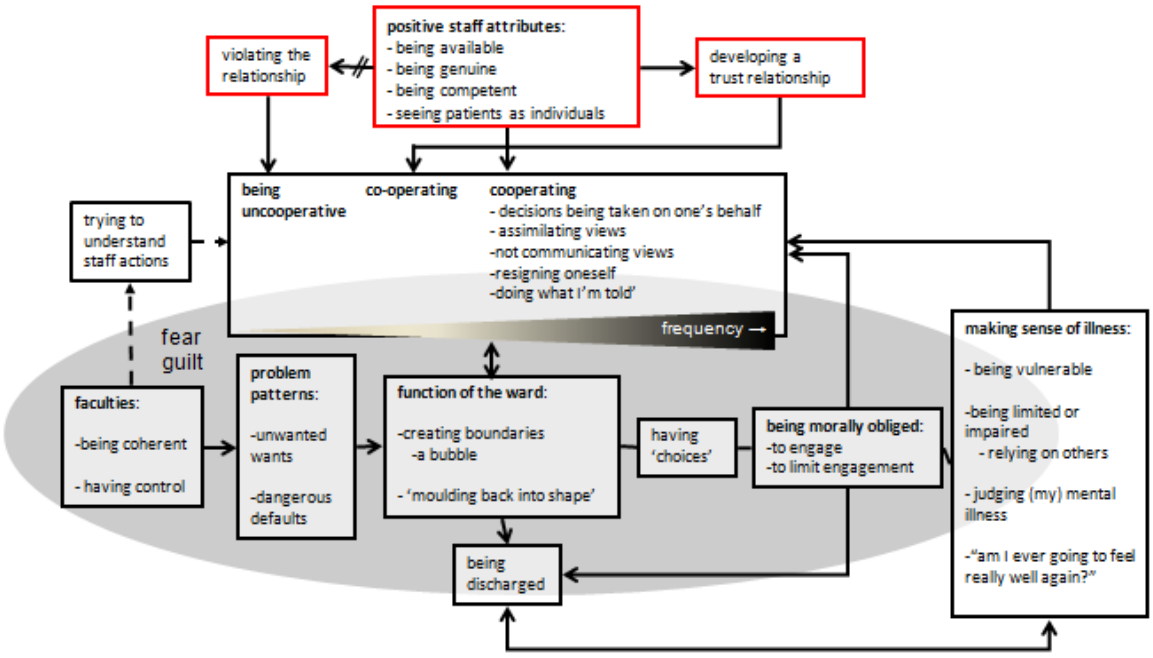


Figure 4.7: Facing choices, relationships with staff.

If interaction with staff is associated with attachment style, these interpretations suggest, there is an implication that patient–staff is an attachment relationship. Many authors have suggested that

mental health staff serve as attachment figures at a time where stressors or the stress of illness itself have initiated attachment behaviours (e.g. Adshead, 1998). Schuengel and van IJzendoorn (2001) have suggested that three circumstances promote attachment in the inpatient setting; isolation from existing attachment figures; activation of attachment system (i.e. distress); and the possibility of a secure base. Though Huntlyburn actively attempts not to isolate patients from existing attachments, the preceding themes have suggested that patients' admission state can be understood as an attachment crisis, and that the physical and affective containment of the ward can be understood as a safe haven. The following themes from interview data indicate the ward is evaluated in attachment terms.

Identifying positive staff attributes was among the most prolific themes. *Being available* is one key attribute. The proximity of people who are approachable, 'make time to talk' and listen, even about difficult subjects, is one of the means by which the ward moulds one back into shape. The offer of extending availability via phone contact is appreciated (though seldom utilised due to the moral obligation to limit engagement). A closely linked attribute might be described in person-centred terms as warmth or *being genuine*. Empathy, friendliness, kindness, concern, and praise were construed as sincere displays of personal characteristics, not therapeutic contrivances. Nonetheless, these qualities are necessary but not sufficient:

> I said 'I'm, I'm not I'm not getting on well with the crisis team, I'm not getting anything out of them.' [##R## Uh huh.] You know, and... when I say that, I'm not criticising them, they were genuinely kind caring loving people. But I'm just saying it wasn't meeting my needs. (Henry)

A positive evaluation also requires an attribution of *being competent*. Bowlby (1988, cited in Dozier, 1990) defined the ideal attachment figure as "stronger and/or wiser" than the self. Valued staff are perceived to possess natural intelligence, expert knowledge and experience. Their professionalism is displayed in their skilled communication and their capacity to limit their personal response to distressing disclosures or contrary behaviour. The most important staff quality is that of *seeing patients as individuals*, 'human beings', 'more than a number'. This attitude is manifested in respectful interactions, not lecturing or patronising, and in a flexibility of approach to the 'rules' of the ward:

> And, the first few days, I was, I didn't leave my bed hardly. And I think credit goes to = *staff nurse* = because she sort of gradually started coaching things out of me. [##R## Yeah.] Eh, and she was very good. Em, so I mean after that point, em, I began to see them as, as working with me. [##R## Right.] And I think what helped was, 'it's meal time', I said 'I don't care, I'm not having a meal'. You know because I just didn't feel like, sitting in a room with people. [##R## Yeah.] And, and they started bringing me meals. And suddenly you start... you know, OK, well they're, you know these people are incredibly helpful. (Jack)

The above excerpt can be interpreted as staff providing a corrective experience to Jack's negative internal working models of others by remaining engaged and responsive (see Adshead 1998). It is not hard to discern in the attributes of availability, genuineness, competence and individualism, those of the ideal attachment figure (Bowlby 1988), though note that Parsons' (1978) sick-role has a complementary professional-role, involving intelligence, morality, expertise and willingness, also closely aligned with these themes. It is extremely surprising therefore that there was only one minor relationship between positive evaluations of staff attributes and attachment styles: significant contributors to being available scored lower on preoccupied attachment. Interview data offer one possible explanation. Narratives suggest that for some participants, *developing a trusting relationship* with staff is default: staff are presumed to possess the above attributes by virtue of being mental health professionals. For others a trust relationship has been earned by the consistent demonstration of all these attributes over a period of time. This latter group score more highly on measures of fearful and dismissing attachment, but still evaluate staff positively. This suggests that ward staff have – at least temporarily – overcome avoidant internal working models.

Perception of positive attributes facilitates trust and co-operation, and at its best this is experienced as staff and patients working together in an environment of mutual learning. Where staff are evaluated positively, even apparently difficult interactions – e.g. challenging, offering 'constructive' criticism – can occur without relationship breakdown:

> Although, nobody wants to hear something horrible said to them. [##R## Mmm hmm.] But sometimes that has to be said. To get you out that negative thinking. But that it's, understanding o' how they say it, and I mean they dinnae come out and just say 'well cheer up love, get on with it, there's worse things happen'. It's

> their approach to you, that makes you feel, you are worthy of my time... You have got a lot to give in life. (Linda)

A current question in the literature is whether patients form attachments to individual staff members, to teams, or to institutions. Originally conceived, attachment bonds "involve a specific figure who is not interchangeable" (Cassidy 1999, cited in Ma, 2007) however Goodwin *et al.* (2003) used grounded theory methodology to develop the Service Attachment Questionnaire. To the extent that a service performs in the six domains (listening, consistency and continuity, giving enough time, safe environment, helpful talking, human contact) it is understood to meet attachment needs (in their validation sample inpatients indicated the lowest levels of service attachment). Further projects have identified relationships between attachment style and interaction at the service level (Blackburn *et al.*, 2010; Catty *et al.,* 2011). In this project, staff attributes are interpretable in attachment terms. Staff are also generally referred to as 'staff' without differentiation by name or by profession/grade, suggesting that it is indeed the team or ward that is the locus of attachment, not the individual. Note that Thomas *et al.* (2002) interpreted non-use of staff names as indicating absence of personal connection. This was not the case in the current project, where participants gave both generalised and specific accounts of meaningful interpersonal relationships. Where negative interactions are recounted, they typically involve new or unknown staff members, often outwith the health board area.

Negative interactions occur when staff are perceived to be *violating the trust relationship* by being rejecting, blaming, critical or accusatory. They make assumptions, or generalise between patients, trivialising distress. They are inflexible, and understood to be 'just doing it for the money'. Participants respond by *being uncooperative*. This theme represents situations wherein participants hold, and persist in holding, views conflicting with staff. These include disagreement about admission, discharge or treatment and may be manifested in escalating help-seeking demands despite these previously having been denied, or non-compliance with expected behaviours. Un-cooperative behaviour is typically driven by fear. For example Henry, whose help-seeking rapidly escalates from demanding phone calls via erratic behaviour to suicide attempts, feels compelled because a refusal to admit him amounts to putting his life at risk:

> I hope it never happens, if I got unwell, or I felt I needed to be in hospital, and they wouldn't let me in.
>
> ##R##
> What do you think would happen?
>
> I think I would overdose, deteriorate and overdose. [##R## Yeah.] That's what I think would happen. But I wouldn't blackmail them and say, [##R## Right.] 'if...' because someone blackmails, blackmails people 'if you don't let me in I'll take an overdose'. [##R## Mmm hmm.] I think I would feel rejected. [##R## Right.]And, that they don't feel that I need the help I need.

This can be understood as a hyperactivating strategy intended to bring about proximity to the attachment figure (the ward). In a focus group study Lester *et al*. (2005) found that both patients and GPs reported exaggerating symptoms to gain access to secondary care in order to avert deterioration. It is unsurprising in this project that significant contributors to being uncooperative report more fearful and dismissing attachments. That both attachment anxiety and avoidance are increased in this theme may reflect the theme's inclusion of active and passive strategies. Expressions of non-cooperation can be explicit, for example verbal engagement or aggression, but most are implicit, such as Brian, Colin and Jack's initial, passive refusal to cooperate with mealtimes. Where participants have been openly uncooperative they tend either to retrospectively excuse their actions as a manifestation of illness, or 'stick to their guns' by alluding to subjective knowledge and experience:

> you can sort of tell yourself when you can, you can battle it and when you can't. (Angela)
>
> I know what I'm capable of when I'm like that. (Henry)

It is noteworthy that some participants feel they are empowered to be uncooperative but not inclined, while others feel inclined to be uncooperative but not empowered. The latter group score more highly on the preoccupied attachment subscale, which is consistent with a state of mind which is too fearful of rejection to contest others' views.

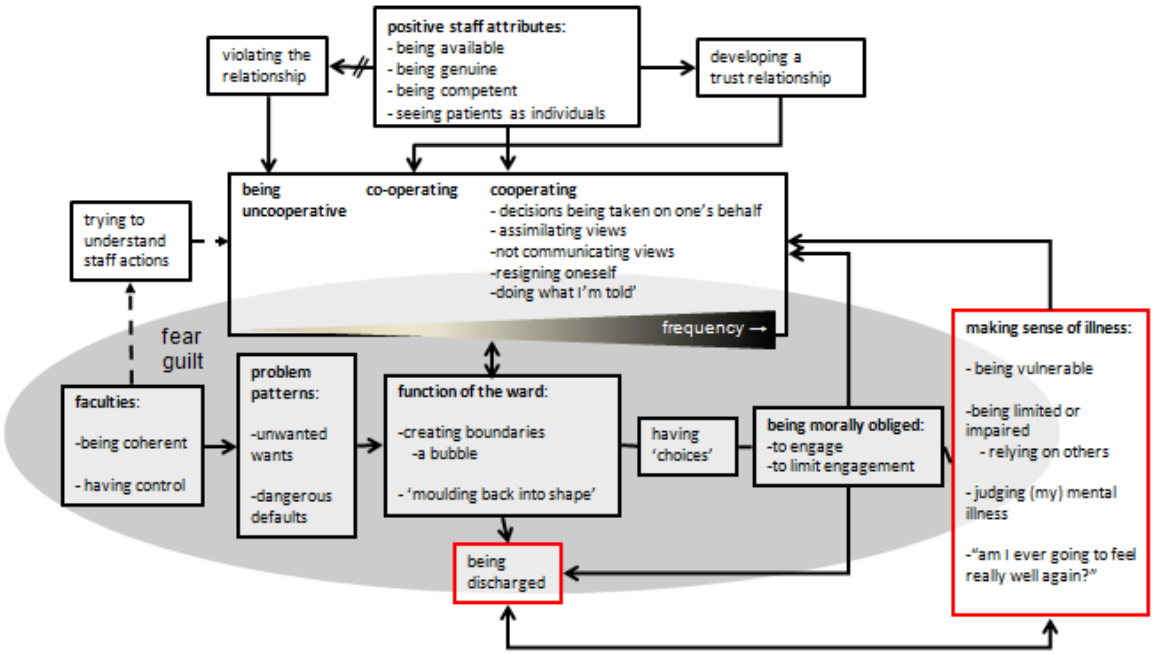


Figure 4.8: Facing choices, being discharged and making sense of illness.

I have interpreted the preceding themes as indicating that admission to Huntlyburn, by means of a containing physical environment and available, responsive relationships, is meeting the attachment needs of patients in crisis. If this is the case then the theme of *being discharged* may be interpretable as a separation event (e.g. Adshead, 1998; Goodwin, 2003) and we would expect the discharge period to be marked by reactivation of threat systems, decreased mentalisation and implementation of attachment strategies. Aspects of participant accounts of being discharged accord with this. Participants express intense, mixed emotions, gratitude, hope and satisfaction, but also guilt and apprehension, even fear. Emotions vary in accordance with the extent to which participants feel the function of the wad has been fulfilled. The majority, whose unwanted wants and dangerous defaults have been satisfactorily managed are apprehensive but cautiously optimistic. For Angela, whose self-harm urges continue, and Fiona, whose protective bubble is about to be burst with no discernible reduction in external stressors, there is intense fear, protest, and renewed help-seeking. Emotions also vary in accordance with how and by whom the prospect of discharge is raised. Where discharge date is presented as a fait accompli, planned or otherwise, it can be perceived as an inflexible, punitive limit (participants who described this perception scored more highly on preoccupied attachment, and it is notable that non-negotiable

discharge dates are typically set specifically to avert 'excessive' help –seeking). When it is initiated or negotiated by the participant, even where compromises are made, discharge is more often perceived as a goal – though they may still have concerns about its attainability.

Whatever the circumstances, discharge – even for participants with a long history of illness and admissions – is a period of self-reflection. Derek described it as being at a crossroads, planning where to go while waiting for the light to change. It is a time of *making sense of illness*, and the experience of discharge is reciprocally related to the sense that is made. If the themes concerning evaluations of staff can be discussed in terms of internal working models of others, so the themes concerning self-reflection can be discussed in terms of internal working models of self.

Each patient understands him or herself as *being vulnerable*. They are vulnerable to stressors, more so than 'normal' people – most doubt their capacity to cope with a life event such as bereavement. They are vulnerable to relapse, the return of unwanted wants or dangerous defaults, and hence to their own actions. A direct, even inevitable, causal relationship between stressors and relapse is anticipated by some. Significant contribution to the theme of being vulnerable was associated with higher ratings of depression, a more fearful attachment style, and a closer identification with self as illness on the PBIQ, all consistent with an internal working model of self as one who is unable to depend on one's own inadequate resources. It was also associated with lower ratings of social support. This may be accurate: it has been observed that social networks of people recently discharged from inpatient psychiatric care are smaller than those in community mental health control groups (Dickinson *et al.,* 2002) and this decline is understood to predate hospitalisation (Horan *et al.,* 2006). It is also possible that depressive symptomatology results in an unrealistic negative appraisal of available support (though associations between depressive symptomatology and perceived social support are not always replicated; e.g. Simms & Mulholland, 2008). Narrative data do not favour either explanatory model, but do support the general inference that perceived shortage of social support heightens sensation of vulnerability.

There are close links between being vulnerable, and *being limited or impaired*, another aspect of the self following illness. Participants describe their lives as restricted at a micro and macro level: they cannot drive, meet with friends, look after their grandchildren; they cannot return to work or form relationships. They become reliant on others, a circumstance which Rees-Jones *et al*. (2009) implicated in their category of 'social vulnerability': being 'under threat of harm caused by the omissions, neglect or positive actions of others' (p.637). In some cases limitations are the direct result of symptoms of illness. A sense of being vulnerable operates as a limiting factor in two ways. First, people are reluctant to make plans because they never know when they might relapse. Secondly, people are reluctant to 'do too much' for fear of *causing* relapse: Brian, attributing his illness to overwork, chose during admission to take early retirement but is now faced with the bewildering choice of how to safely fill his time. Participants face a future restricted in terms of geographical, economic, social and romantic possibilities. It is unclear to what extent this is unnecessarily self-imposed, but ironically the outcome is isolation, boredom and low self-esteem, all risk factors for relapse. Significant contribution to the theme of being impaired was associated with higher ratings of anxiety and depression, and increased identification of self as illness. SOS actual and discrepancy ratings indicated higher levels of social support, but that these were *too high,* suggesting that the strategy of relying on others was effective but dissatisfactory. There was an unexpected finding within PBIQ ratings that significant contributors indicated less concern about control over illness. This may reflect participants' sense that they can control their illness *by* limiting themselves.

Some participants are changed by their illness, some change themselves in response to their illness. '*Am I ever going to feel really well again*?' is a theme which draws together participants' beliefs and concerns about the likely course of their vulnerability and impairment. All participants want to be well again, but their confidence in doing so hinges on the extent to which they conceptualise their illness as part of themselves. At one extreme is Fiona, who said 'when I became ill it was because of things that had happened'. Being ill is by definition *not* to be herself (see coherence) and though she is limited now, when she returns to herself she will resume her life plans as before. At the other extreme lies Gillian, whose illness experience is part of who she is. Between are those like Brian, whose 'breakdowns' are not part of him but something he is susceptible to, rather like an infection, or Jack and Linda, for whom depression

is a latent character trait, a 'black dog' lying in wait. Fear of relapse and frustration at the unpredictability of periods of wellness are universally described. Unsurprisingly, significant contribution to this theme was associated with a greater identification as self as illness on the PBIQ. It was also associated with increased depression, and it is plausible that pessimism is a manifestation of depression: Lecomte *et al.* (2010) found that low depression scores were predictive of optimism in populations with early psychosis and severe mental illness. However negative beliefs about illness as measured by the PBIQ, have been found to be associated with hopelessness (White *et al*., 2007) and lower status of anticipated future self (Iqbal *et al.,* 2000) even when current depression is controlled for.

Taking into account these understandings of their particular situation, participants describe *judging (my) mental illness*, a theme which considers the place or value of people (including themselves) with mental illness in a wider social context. A common strategy in accounts was to compare and contrast mental illness with a physical illness, usually a broken limb (participants with depression tended also to compare and contrast with 'proper' mental illnesses). They observed variation on three dimensions. Mental illness is less visible, there is no clear justification for assumption of a sick role. It is less relatable, people who haven't 'been there' can't imagine what it's like. It is more likely to be perceived as self-inflicted (especially after self-harm) and therefore as shame-worthy and undeserving of a caring response. For all these reasons participants reported a lack of empathy and openness in those around them. Some but not all participants expressed negative self-judgements, e.g. that their illness was a manifestation of personal weakness. Some but not all people anticipated these judgements from other people, though fewer gave actual examples of having encountered these, and some were able to recognise that they were potentially projecting their own views into others. Tait *et al.* (2004) had found that participants with a sealing over recovery style did not evaluate themselves more negatively, but did anticipate more negative evaluations from others. It is interesting that significant contribution to this theme was not associated with perceptions of stigma or of social containment on the PBIQ, nor was it associated with attachment scales, which one might expect given the identification of self as flawed and others as critical or rejecting. It was associated with increased identification of self as illness, and with lower actual – but not ideal – social support,

perhaps reflecting a reluctance to solicit or accept support in the case of mental (as opposed to physical illness).

How people make sense of illness is not an academic aside. Patients' beliefs about their illness; its controllability, its role in their identity, their status in society have been empirically linked to depression after acute mental illness (Birchwood *et al.,* 2000), to hopelessness – a risk factor for suicide – in schizophrenia (White *et al*., 2007), to perceptions of unmet need, treatment adherence, functioning and help-seeking (Broadbent *et al*., 2008). From qualitative research we see that an understanding of how one came to be ill shapes interaction with staff (Sayre, 2000) and that a sense of self-efficacy is integral to any recovery (Mancini, 2007). In these interviews we have seen how experience and evaluations of impairment lead participants to be fearful of their own choices, to seek restriction of their choices, to turn their choices over to others and to consider their future choices as limited. It is likely that these perceptions will have a substantial impact both on participants' subjective experience of the post discharge period, and its outcomes in objective terms.

Chapter 5: Reflective statement.

At the outset of this project I was, in all senses, 'new to this'. New to the subject, neither I nor anyone close to me had experienced inpatient psychiatric care. New to the setting, I had only recently begun my placement at Huntlyburn. New to the methods, I had – perhaps misguidedly – viewed my thesis as an opportunity to acquire a new set of skills. The concept of researcher reflexivity seemed an academic complication. I could of course understand that, for example, years of training in psychology might pre-dispose me to see psychological concepts in a transcript more easily than a surgeon might. But co-constructing? Nonetheless I dutifully began a reflective journal and proceeded to fill it with frankly un-insightful and commonplace observations.

It was midway through the project that I re-read Willig's (2008) section on *critical language awareness* and decided to closely review my own notes and memos. I noticed that I had referred to one participant as having 'abdicated' responsibility for care decisions, and was struck. Perhaps it is unique to the UK, where Wallis Simpson is still a household name, but I understand the word *abdicate* to have connotations of selfishness and weakness, of leaving some unwilling other person to take on one's role. At that moment I realised I was approaching my data with the unquestioned assumption that a person *would and should* want to be in control of themselves and their care.

In my defence, the veneration of choice and self-determinism is not simply a personal value, but a cornerstone of contemporary western culture. It is enshrined in our political constitutions ('life, liberty and the pursuit of happiness'), our classical mythology and popular entertainment (from Spartacus to Frank Sinatra), and is the driving rhetoric of current healthcare reform ('Yes to patient choice'; Clegg, 2011). If freedom and choice are *human* rights, what then is the status of those unwilling or unable to exercise choice?

My own experience has been very different from that of many of the project participants. I have sometimes had to make difficult choices. I have sometimes had to consult experts to support my choices. I have sometimes chosen to let others choose on my behalf. I have never felt myself

incompetent to make a choice, or felt that my choices were limited by some inherent aspect of my being. How has my personal experience in this cultural context affected - and been affected by - this project?

The very 'otherness' of patient experience aroused my curiosity. I was genuinely interested to discover what I could about an alternative perspective, and this lent energy to the project. Despite enthusiasm and new self-awareness though, a 'pro-choice' bias is still detectable in my work. Reviewing transcripts I see many instances where I have investigated 'negative' responses to perceived lack of choice, but many where I have failed to pick up on or probe allusions to positive responses. Indeed, in some instances I wonder if my questioning induced *meta-acquiescence*: agreeing that agreement is agreeable. Though I have tried to remain self-aware in my interpretations, it is inevitable that the resulting theory, while grounded in the interview data, reflects the questions I posed.

How has the research affected me? In 'professional' terms I have learned:

- that researcher reflexivity is more than an academic abstract
- that a quick 'self-scan' at the outset of a project is not sufficient to identify assumptions and biases, but ongoing careful scrutiny is required
- that 'bracketing' of researcher bias – if theoretically possible – is beyond my own capability.

Again, un-insightful and commonplace observations. The more personal effect is more difficult to articulate, and perhaps best explained anecdotally. Toward the end of the project I had a flash of insight/memory, recalling a passage which had struck me in Margaret Atwood's *The Handmaid's Tale*, a novel I read nearly fifteen years ago:

> There is more than one kind of freedom... Freedom to and freedom from. In the days of anarchy, it was freedom to. Now you are being given freedom from. Don't underrate it. (p.34).

I returned to the book and found that, as an idealistic sixteen-year-old, I had underlined and annotated[6] not only these lines but many passages referring to freedom and restriction: essentially to choice. I re-read the book able to compare and contrast (with wry amusement) my own naïve early commentary with a more mature appreciation of alternative interpretations: frightening though totalitarianism might be, were there not some for whom the 'days of anarchy' were also frightening?

I hope that the process of conducting this research hasn't been the only means by which I've acquired a touch of subtlety and perspective over the intervening years. It is not entirely news to me that there are other ways of thinking than my own. I think wide reading has been part of this. But in terms of power to induce careful thought, no satirical fiction or intellectual examination has come close to this recent process of immersing myself in first-hand accounts. I plan to build on this experience (*not* by constructing more grounded theory, by reading more biography) and hope to become more sensitive professionally and personally by doing so. I would like to retain at least a little of my youthful idealism though.

[6] I do not make a habit of annotating fiction as I read. I can only imagine this was in the service of a long-forgotten high school English assignment. This does add yet another layer to considerations of reflexivity – though I was not consciously aware of it, I have apparently been interested in issues of choice for a long time.

Chapter 6: Discussion.

Summary of findings:

This project has attempted to further our understanding of how patients conceptualise the experience of discharge, and to ascertain the role of measurable psychological constructs in their conceptualisation. Participants' conceptualisation can be briefly summarised as follows:

People are faced with choices throughout the process of their illness, admission and discharge. In the acute phase of illness, people experience a diminished sense of self and self-efficacy. They are unable to make or implement adaptive choices, and may feel urges to make maladaptive choices. Feeling fearful and guilty about potential consequences of their mental state, people look to the ward to temporarily restrict their choices: erecting and maintaining boundaries they are presently unable to. During admission people face a number of decisions, though the relationship between the presentation of options and the perception of having meaningful choices is not a straightforward one. Perceived choices are restricted by fear, by mental state, and by implicit moral obligations regarding treatment engagement. Engagement with staff is a crucial means of approaching choices: in some cases people work jointly with staff, more frequently they cooperate with staff, effectively allowing choices to be made on their behalf, a process which is facilitated by positive evaluations of staff. Discharge is conceptualised as an emergence from protective boundaries and a resumption of responsibility for choices. It is a period of reflecting on self and self-efficacy. Future choices are typically perceived as restricted by vulnerability and impairment, and are faced with trepidation.

As previously referenced, many of the constructed themes are closely aligned with pre-existing constructs in attachment theory, specifically metacognitive capacity, mentalisation and reflective functioning. The themes of coherence, control, unwanted wants and dangerous defaults can be understood as representing aspects of the experience and consequences of impaired mentalisation. The functions of the ward are broadly those of a safe haven; a location or person providing affective containment in times of fear and distress (Bowlby, 1969, cited in Dozier, 1990). The rhythms of the ward and the availability of practical support mould one back into

shape, a process comparable to the development from co-regulation to self-regulation (Sbarra & Hazan, 2008). The attributes of valued staff were those of a responsive caregiver (e.g. Dozier & Bates, 2004; Ma, 2007). Where staff violate the role of caregiver by appearing rejecting participants describe escalating behaviours clearly interpretable as hyperactivating strategies (Mikulincer *et al.*, 2003). More detailed investigation may confirm the author's inference that passively uncooperative behaviours (e.g. refusing meals) represent deactivating strategies associated with avoidant attachment styles.

Where themes have been interpreted within an attachment framework, data from standardised assessment of participants have typically supported the interpretation. For example the interpretation of behaviours within the theme of being uncooperative as attachment strategies was supported by the finding that contributors to the theme indicated more insecure attachment styles.Though there were many instances where no relationship between theme contribution and measured attachment style was found though they were anticipated, for example between attachment and evaluations of staff, there were no significant instances of relationships in the direction other than anticipated.

In addition to illustrating the utility of existing attachment concepts in understanding the inpatient experience, this project has highlighted opportunities to extend current research into attachment and mental health. Though there has been much theoretical and empirical investigation of mentalising, there has been very little phenomenological or experiential literature describing what it *feels like* to be in a state of impaired mentalisation or dysregulation. Fonagy and Luyten (2009) include a section of 'aspects of phenomenology', but this is extrapolated from experimental data, not first-hand accounts. Vanheule and Hauser (2008) offer an exception, observing in depressed adolescents' narratives that inability to comprehend the intentions of others (an 'unbearable riddle') precedes despair and helplessness. Participants in this project gave vivid accounts of their experience, detailing a frightening loss of sense and self, followed by experiences of guilt, shame, inadequacy and limitation, as well as cautious hope. This project also demonstrates that a phenomenological approach can generate new avenues of interest. For example the suggestion that engagement with services may in part depend on

clients' ability to mentalise staff intentions and motivations has not, to the best of the author's knowledge, been previously considered.

A central tenet of attachment theory is that the attachment system is activated specifically when an individual is 'frightened, tired or ill' (Bowlby, 1969, p.371). Thus far, research has examined impaired mentalisation, affect dysregulation and activated attachment strategies as *responses* to perceived threat. In these narratives it is apparent that these experiences are *themselves* threatening. Participants describe the experience and consequences of loss of coherence and control as intensely frightening. The process of accessing appropriate support is exhausting, and often exposes one to staff/services who are rigid and rejecting, further exacerbating the attachment crisis. The 'frightened, tired or ill' individual ends up more frightened, more tired, more ill. Mikulincer *et al.* (2003) have suggested that chronic attachment system activation generates a 'self-amplifying cycle of distress' (p.85) because absorption in attachment activities leaves one vulnerable to new sources of distress. I suggest an alternative (though not mutually exclusive) mechanism: distress is 'self-amplifying' because the consequence of distress – dysregulation – is itself distressing. Further exploration of this claim would be a valuable addition to the mentalisation literature.

Several themes in this project were also closely aligned with concepts from the 'appraisal literature' (the body of research considering the impact of people's beliefs about illness on their experience and outcomes) in particular the ideas of control, vulnerability, impairment and social status. Interpretation of themes within this theoretical framework was supported by consideration of contributing participants' responses to the PBIQ. Relationships were consistently identified, however in contrast to relationships between constructed themes and attachment subscales, relationships were not always in the expected direction; for example the finding that those who most frequently mentioned feeling vulnerable indicated less concern about 'control over illness'. Such findings prompted novel interpretations which add to the richness of the analysis, but they also highlight the risks of taking quantitative data at face value: sometimes a survey statement might not mean what you think it means. This may be particularly pertinent in the case of the PBIQ, where the source of the survey statements is not given in the original publication (Birchwood *et al.,* 1993).

Though not exclusive in its terminology, the PBIQ has predominantly been used with populations diagnosed as psychotic. The identification of meaningful relationships between PBIQ ratings and participant experience in this mixed sample suggests that its concepts, like mentalisation, may be 'transdiagnostic'. That some themes were related to measures of attachment *and* of illness beliefs is not problematic: the two theories are not mutually exclusive, indeed may be compatible if one conceptualises negative beliefs about self and illness as part of a negative working model of self.

Though a small number of relationships were found between themes and measures of psychopathology and social support, these were not numerous and did not indicate any coherent explanatory framework. In an exploratory project where multiple measures were selected to be wide-ranging it was highly unlikely that all would emerge as theoretically relevant. Thus the absence of consistent associations with these measures is not considered to be a threat to the validity of the themes.

Notably, the themes concerning moral obligations, though consistently referred to by a majority of participants, did not clearly align with any theoretical framework (though there were some relationships with PBIQ scales, interpretation was speculative rather than consistent with any existing understanding). Because the idea of moral obligations in this context is poorly understood at present but clearly salient to participants, I would highlight this as an important area for future research.

Initiating research questions

It will be observed that these findings vary significantly from those anticipated at the outset of the project. In early development stages it was proposed that participants would use the initial interview prospectively, to discuss their hopes and fears, practical and personal, for the immediate post-discharge period. The follow-up interview would then allow us to compare and contrast prediction with experience, ultimately enhancing future discharge planning. In the event, participants tended to use both interviews retrospectively, to tell the story of their illness

and admission, and relate their experience of the ward. Consequently, though the current findings do make reference to discharge, this is in the context of a wider consideration of choice, engagement and self, with emphasis on the pre-discharge period.

In an inductive qualitative project seeking to develop understanding in a subject area without a current, clear evidence base, a shift in emphasis is neither unacceptable not unexpected, though it is incumbent upon the researcher to consider what insight any variation may offer regarding the implicit assumptions underlying the initial research question (Willig, 2008). In this instance we see with hindsight an – unsubstantiated – assumption that people will be future-oriented at time of discharge: looking forward, whether optimistically or otherwise. In fact most participants appeared still to be processing the events of the recent weeks and months, as yet unable to clearly contemplate the future. Undermining this assumption of future-orientation may be a valuable outcome in itself, obliging us to carefully consider the expectations we have of patients at discharge.

Despite the shift in focus, one initial aim of the project – to develop the descriptive report of the Highland User Group (HUG, 2003) into a broader, theoretical work – has been met. Re-examining this document, substantial commonalities can be seen between the comments of Highland service users and themes in the current project, particularly with reference to the functions of the ward, moral obligations, engagement strategies and making sense of illness. Indeed the majority of quoted comments from HUG would be directly codeable into the current coding structure. This is an excellent example of the reciprocal relationship between a developing analysis and existing literature. The analysis replicates the findings of a descriptive work, and develops these further by generating an explanatory framework which can be understood in relation to existing psychological theory. In return correspondence with prior literature and findings validates the developing analysis, triangulates it within the literature and points to further analytic possibilities.

Appraisal of project

Irrespective of their degree of correspondence to the initiating question, any findings are only as robust as the research process itself. Many authors have addressed the issue of appraising or validating qualitative research, some even questioning the very attempt to do so: taking relativism to the extreme it has been argued that all interpretations are equally valid, therefore the means of interpretation are irrelevant (e.g. Forshaw, 2007). In general though there is recognition that where one claims 'knowledge' – even where one acknowledges multiple alternative 'knowledges' – one must be prepared to demonstrate how such knowledge was acquired and subject the process to scrutiny (e.g. Willig, 2008; Yardley, 2000).

There the consensus ends: there are as many recommendations for enhancing and exhibiting 'quality' in qualitative research are there are articles on the matter. These are variously conceptualised as guidelines, criteria, principles *etc*. and vary in their origins, number, and degree of specificity and abstraction. A summary of prominent examples is given in Table 6.1. Synthesising sources (though note that the recommendations of Elliot *et al*. 1999 are themselves a synthesis of pre-existing guidance) we see that these recommendations fall into two broad themes: methodological rigour and interpretation of findings.

Table 6.1: summary of examples of recommendations for appraisal of qualitative research.

Source/conceptualisation	Features
Elliot *et al*. (1999)	Owning one's perspective
Publishability guidelines pertinent to qualitative research	Situating the sample
	Grounding in examples
	Credibility checks
	Coherence
	General vs specific research tasks
	Resonating with readers
Yardley (2000)	Sensitivity to context
Characteristics of good (qualitative) research	Commitment and rigour
	Transparency and coherence
	Impact and importance
Parker (2004)	Objective?
Criteria for qualitative research	Valid?
	Reliable?
	Neutral?
	Confirmed?
	Definitive?
	Established?
	Coherent?
	Accessible?
	Psychological?

Beginning with Elliot et al. (1999) – "it is not our intent that these guidelines be applied to qualitative research manuscripts as a rigid 'checklist'" (p.224) - each of the sources summarised in Table 5.1 states explicitly that their recommendations are not to be regarded as prescriptive, and that not every criterion will be applicable to every project. Furthermore many qualities, for example coherence, transparency and resonance, are in fact for the reader not the writer to judge. For these reasons it seems unjustifiable to simply select one 'set' of guidelines over another and robotically appraise the current project on a point-by-point basis. Rather this discussion will selectively attend to methodological and interpretive issues pertinent to the current project while acknowledging that these issues may have been arisen within any or all of the listed sources.

Methodological issues

As far as was possible given researcher inexperience and limited time and resources, the methods of grounded theory were conscientiously applied. As described in chapter 2 however, restrictions to the recruitment process precluded the possibility of theoretical sampling, the hallmark method of grounded theory.

Theoretical sampling is the strategic recruitment of informants who have knowledge pertinent to the developing categories. As previously described, ethical concerns were raised about approaching specific patients regarding participation and a passive recruitment strategy was implemented, effectively prohibiting theoretical sampling. As the analysis developed, it would have been immensely useful to interview, for example, an individual who had been admitted to the ward under section and would have chosen not to be admitted, or an individual from outwith the health board area with no pre-existing relationship with community or ward staff. No such individuals came forward and as such there were significant gaps in the categories during development, with the ultimate result that the interview data were inadequate to generate an explanatory framework. In recognition of the absence of theoretical sampling and explanatory model, the analysis has been presented as a thematic analysis rather than a grounded theory. .

As well as those who did not take part, we must briefly consider those who did. Lelliot and Quirk (2004) summarised existing qualitative accounts of life on psychiatric wards concluding that the wards were perceived as boring and unsafe and staff-patient relationships as 'superficial'. The findings of this study stand in stark contrast. Undoubtedly one reason for this is the high quality of the service which Huntlyburn provides; client satisfaction survey data is typically positive (unpublished data). Another reason may be the participant group. Several participants commented during the consent-seeking process on reciprocity: they wished to participate to 'give something back to the ward'. This has three implications. Firstly it offers some corroboration to the category of moral obligations, which made reference to reciprocity. Secondly it offers some justification to the initial concerns that patients may have felt obligated to participate if directly approached. Finally, it raises questions about whether this sample over-represents those who have had a positive experience of admission, who have formed or resumed

an attachment relationship with services and are seeking to extend or 'repay' this by engaging with the project (homogeneity at this level may go some way to accounting for the relatively consistent explanatory narrative despite diversity in demographics, admission variables and reasons for admission). The question of whether patients who volunteer for interview studies differ from the broader patient population has previously been raised (e.g. Goodwin *et al.*, 2003).

There is a possibility that findings may not reflect the experience of, for example, those who had negative admission experiences and/or severed relations with the ward as cleanly as possible. However, sample representativeness is not always an objective of qualitative studies (Morse, 1991, cited in Jeon, 2004). The negative impact of the purposive sampling method in the current project is the lost opportunity to selectively explore alternative events or experiences which would enrich the theory. As described in chapter 2 sampling limitations do not 'invalidate' the findings of the project, but highlight scope for theoretical sampling should the opportunity to extend the project arise in the future.

Theoretical saturation is a closely linked issue, of equal importance in grounded theory and thematic analysis studies. Briefly defined, saturation refers to "the point at which gathering more data about a theoretical category [or theme] reveals no new properties nor yields any further theoretical insights" (Charmaz, 2006, p.189). In effect this means the analysis is as comprehensive as it can be and thus saturation is an ideal, though not a realistic outcome for every study. Critics have commented that many researchers proclaim rather than demonstrate saturation of their categories or themes (Morse, 1995; Suddaby, 2006). This researcher will do neither: the themes in the current study are not yet saturated.

In addition to the 'gaps' previously described due to sampling limitations, there are gaps within themes where codes are of interest but insufficiently populated to be included in the current structure, for example anger and hope were observed as well as fear and guilt. There are also gaps between themes - theoretical links which have been inadequately explored - for example we observed how making sense of illness influenced engagement with staff, but did not observe how engagement with staff influenced making sense of illness. It is the inadequacy of these links which marks the findings as a thematic analysis rather than a grounded theory.

There are several reasons for non-saturation. One is the prohibition of theoretical sampling. Another is the inexperience of the researcher: without the swift subtlety of the experienced interviewer the quality of interview data was mediocre and gaps in accounts passed unnoticed until it was too late for more detailed probing. In hindsight including the potential to re-contact participants for brief theory-checking in the research protocol would have been invaluable. The scope of the study – the discharge experience – was very broad, and the broader the scope, the more data is required to reach saturation (Morse, 2000). Having been more focussed at the outset of the project, or having narrowed the focus earlier in the analytic process would both have improved the chances of reaching saturation. They would not have guaranteed it however: many of the very comprehensive examples of qualitative research are the cumulative work of decades, spanning hundreds of interviews with dozens of participants (e.g. Charmaz, 2006), and are simply beyond the reach of a project such as this.

Reasons notwithstanding, it has been acknowledged that due to significant gaps within and between categories, the findings of this study cannot properly be referred to as a grounded theory. Rather they should be regarded as preliminary, descriptive themes (the generation of descriptive categories has been described as 'abbreviated' grounded theory; Willig, 2008), and accordingly the findings have been presented as a thematic analysis. Descriptive themes may suggest a theory and should serve as the starting point for further research both qualitative and quantitative. This is in keeping with a methodology which stresses ongoing refinement of knowledge: "the published word is not the final one, but only a pause in the never-ending process of generating theory." (Glaser & Strauss, 1967, p.40). Future research should considerably narrow its scope, perhaps focussing on only one or two key categories which are more fully developed and indicate potential theoretical interest. For example the theme of moral obligations is relatively robust, but has scope to be elaborated more fully, and has signified links to important but underdeveloped empirical and theoretical literature. Further qualitative investigation might progress these themes to the status of categories or concepts within a grounded theory, or an empirical study might quantify the respective contributions of psychopathology, emotional state and illness beliefs to patterns of engagement.

Epistemological reflexivity

As well as considering limitations in the application of the methodology, it is necessary to consider how the methodology has itself been a limiting factor:

> Epistemological reflexivity requires us to engage with questions such as: How has the research question defined and limited what can be 'found'? How has the design of the study and the method of analysis 'constructed' the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation? (Willig, 2008, p.10)

We will consider first the features of design and setting unique to this project, before considering the broader context and methodology.

By recruiting participants on the basis of their being presently discharged, and by posing initial interview questions around the event of discharge, we have made an externally observable event the focus of research. This may have encouraged participants to respond with similar focus on externally observable events. Viewed retrospectively, many participants offer a sequential narrative of events (this happened and then this happened…) rather than attending to underlying social processes or internal, felt experiences. While facilitating the structuring of themes, such a focus may have inhibited the depth and richness of participant accounts which is typically sought in qualitative research.

Another aspect of study design which may have inhibited richness of data is - somewhat counter-intuitively - the use of interviews. In an inpatient setting, participants have been 'interviewed' twice weekly in ward rounds. Moreover they have been expected in these interviews to give a clear and concise description of their current state to one or several members of a multidisciplinary team whom they may or may not have encountered before. They are not encouraged to speculate or reflect on 'what is happening here?' As previously described, there were observable limitations to patient narratives; deficiencies in reflection; subject avoidance

strategies etc. These have been discussed in relation to impaired reflective functioning. It is possible that this impairment has been exacerbated by the necessity of making the 'gear-shift' to a very different style of interview than recently encountered. It is possible that extending the time between discharge and interview, or exploring different data collection methods such as diary-keeping, might mitigate both effects.

Another specific feature of the research setting is the nature of the Borders local area which prides itself that 'everyone knows everyone' (NHS Borders & Scottish Borders Council, 2004) and more specifically the Huntlyburn ward, which prides itself on continuity of staff relationships. Patients are on first name terms with staff (and vice versa) through their professional contact, but they are also often social acquaintances, even neighbours. That this will have implications for the potential formation of attachment relationships is obvious, but it is also likely to impact considerations of social judgement and stigma. It would be instructive to compare in more detail the findings of this study to those of the majority of studies, which are conducted in urban centres where both staff and patient populations are significantly larger and more transient (Tait *et al.*, 2004). Note that qualitative researchers distinguish between generalising horizontally and generalising vertically (Yardley 2000). Had this been a quantitative project we might ask whether (exactly) the same pattern would be observed in a psychiatric ward in an urban area, or a medical ward in the same area, or otherwise varied one or more contextual variables (horizontal generalisation). In this case we may alternatively or additionally wish to generalise vertically – if the pattern that we have observed can be abstracted to attachment behaviour, where else in this (or other) settings, might we see comparable attachment behaviours in process?

The situation of this project in a broader cultural context where choice and self-determinism are deified has been discussed in relation to the experience of the researcher. Inevitably this will also affect participants. There was an apparent conflict in participants' accounts of passivity and cooperation, and their professed value of choice and control. I question whether participants - particularly in this inpatient setting, where the rhetoric of the recovery movement is pervasive - who already experience shame and inadequacy as a response to their illness, are really 'able' to

defy cultural convention and state that they prefer to let someone else take control, even if this were the case?

A final aspect of study design to be considered is the use of mixed methods: what did the inclusion of standardised measures add to the project? As previously described they have facilitated the comparison of constructed themes with existing theoretical constructs, and indicated potentially testable hypotheses, for example that service engagement reflects capacity to mentalise about staff actions[7]. However, bearing in mind the social constructionist stance of the project, we must be clear about the limits of what these measures have 'shown'. That constructed themes show clear relationships with measures of attachment (for example) has not *proven* attachment theory. Attachment theory remains a social construct, it is no more objectively true than it ever was. All we have demonstrated is that the concepts of attachment theory, such as mentalisation, internal working models, separation events, are useful in understanding patients' experience of discharge.

Implications of the findings

With these caveats in place, there are implications of the findings at the micro and macro level. The day-to-day management of individual patients in the ward setting may be enhanced by a greater awareness among ward staff of issues of attachment and illness appraisal. For example, staff should be aware that patient choices may be made in response to short term attachment needs rather than 'rational' long-term goals, and should aim to satisfy the former without compromising the latter. Careful consideration should be given to how, and crucially by whom, choices are presented, as it is likely that they will be perceived differently depending on the evaluation of the presenter in attachment terms. Staff should be aware that participants at the

[7] Note that measures in this project were selected for face validity and ease of use, and may not be the most appropriate measures for a hypothetico-deductive design. For example Riggs *et al.* (2007) found that self-report (typically assessing romantic attachment) and interview measures (assessing attachment states of mind) gave uncorrelated classifications when administered to inpatients. In any future empirical research measures should be selected with specific hypotheses in mind.

time of discharge are still making sense of their illness experience, and until they have done so struggle to orient themselves to the future. While this continues it may be inappropriate to present them with long term choices e.g. concerning housing and employment. The suggestion that all mental health staff attain a basic understanding of attachment issues has been made previously (e.g. Goodwin, 2003; Berry *et al.,* 2008)

The findings of the project illustrate an ongoing debate in academic, clinical and political spheres about patient choice. Choice and control are dominant themes in the recovery movement (Bonney & Stickley, 2008; Bradstreet, 2004) and service user surveys consistently find that patients want more choice and control in their treatment (Simons *et al.,* 2002). Within this literature there is typically an equation of the 'traditional' patient role with submission to a controlling paternalistic system and a call to reform roles (e.g. Colombo et al., 2003). Yet respondents in this study took a different tone: they sometimes 'go along with' decisions made by others and their choices are sometimes restricted, but they are not necessarily dissatisfied with this. Understanding within the framework of attachment theory can make sense of this: the ward is functioning as a safe haven, provided it does so in a flexible and individualised way, containment and protective restraint are what is wanted ('I chose not to choose'; Welsh, 1993).

This resonates with growing recognition in the literature that what has been termed the 'just maximise choices' (Thaler & Sunstein, 2009) approach to improving services is inadequate, because individuals' willingness or capacity to engage in choice-making is a complex function of internal and external factors and may vary over time (Bradstreet, 2004; Jacobson & Greenley, 2001; Ochocka *et al.* 2005). The findings of this study suggest that attachment system activation and subsequent impaired mentalisation is one mechanism by which choice-making capacity is temporarily impaired. It would be instructive to investigate whether interventions such as mentalisation-based therapy (Allen & Fonagy, 2006) might enhance choice making capacity by reducing the frequency or duration of episodes of impairment.

This project contributes to a growing body of literature indicating that people with mental health problems look to services to meet attachment needs (e.g. Goodwin, 2003; Ma, 2007) in particular to contain and restrain in times of crisis (e.g. Laithwaite & Gumley, 2007; Johannson & Eklund,

2004; Thomas *et al.,* 2002). The inpatient setting, which offers a secure physical environment and continuous staff presence, is uniquely fitted to meeting these needs (Bowers *et al.*, 2009). Yet mental health policies consistently undermine their capacity to do so (Blackburn *et al.* 2010; Catty *et al.,* 2011; Goodwin, 2003; Hummelvoll & Severinsson, 2001).

For example consider the Scottish National Health Service commitment to reducing inpatient readmissions (Delivering for Mental Health, 2006). This ultimately necessitates raising the threshold for admissions. Participants in this study, in keeping with the predictions of attachment theory, describe perceiving refusal of admission as a rejection, and responding by escalating their communication of distress and risk-taking behaviour in an effort to force reconsideration of what is in effect an ongoing decision (Bowers *et al.,* 2009). The admission decision is one example of a fundamental tension between mental health policies and the recovery approach. Recovery models indicate that patients have a responsibility to request appropriate support when needed (e.g. Broadbent *et al*. 2008; Jacobson & Greenley, 2001). Yet a gatekeeping stance to service provision responds to requests for support with a demand for proof of need; inevitably playing into the kind of escalation strategies noted in this study and others (e.g. Lester *et al.,* 2005). Tait *et al.* (2004) characterised an attachment-sensitive service as 'on tap but not on top' (p.414), available and responsive, but leaving patients in control. It is almost impossible to reconcile this with current policies about keeping people out of hospitals.

One means of approaching the conundrum is to reconsider the way in which inpatient care serves attachment needs. As described in the current project and others, the ward functions as a safe haven (e.g. Laithwaite & Gumley, 2007; Thomas *et al*., 2002) and is valued as such. Lelliot and Quirk (2004) have less charitably described it 'a non-therapeutic dumping ground' (p.297): a holding-pen which provides affective containment but does little to address underlying difficulties or deficits. The ideal attachment relationship however, functions not only as a safe haven, but as a secure base from which to explore and develop (Bowlby, 1969). Mikulincer *et al.* (2003) observed that from a safe base one can 'broaden and build' one's own resources, but that this can only take place after relief is obtained and security is restored.

It may be possible to enhance inpatient care in order to accomplish this. By respecting patients' requests for admissions without reinforcing safety behaviours; by providing sustained encouragement from respected sources and mastery experiences (both facilitate the development of self-efficacy, central to recovery; Mancini, 2007); by managing delayed discharges better such that the ward does not become a holding pen for indefinite periods, and by the provision of formal psychological therapy with a mentalising focus, the ward may promote self-regulation and ultimately undermine need for its containing function.

This is not an original proposal. Marrone in 1998 (cited in Goodwin, 2003) made an early suggestion that considerations of attachment should inform mental health policy development. Nearly a decade later Seager (2007) made a formal recommendation that all mental health services should be evaluated in terms of their ability to meet clients' attachment needs. It remains to be seen whether, a further decade later, attachment sensitive services will actually have come to pass.

Chapter 7: Journal article.

Presented in accordance with Author Guidelines for Psychology and Psychotherapy: Theory, Research and Practice (see Appendix 2).

‘Facing choices’: A mixed-methods approach to patient experience of care and discharge in an inpatient mental health unit.

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Abstract

Objectives: This paper addresses patients' conceptualising of the experience of admission to and discharge from an inpatient mental health unit, and the role of measurable psychosocial constructs in this conceptualisation.

Design: An embedded mixed-methods design was employed. Themes developed using thematic analysis were compared and contrasted with standardised assessment ratings.

Methods: Twelve adult patients of an acute mental health unit took part in two separate interviews about their experience of admission and discharge, and completed standardised measures of anxiety and depression, social support, attachment style and illness beliefs. Interview data were analysed using social constructionist thematic analysis. Relationships between participants' contribution to constructed themes and their responses to standardised assessments were discussed in the context of extant literature.

Results: A total of fourteen themes were constructed, organised around a central theme of choices, planning and decision making. Many themes were comparable to existing constructs in attachment theory and the literature addressing illness appraisal, including mentalisation, the safe haven, internal working models, self as illness and shame. Standardised assessments supported and enhanced these interpretations.

Conclusions: Understanding of the process and adaptation to the inpatient experience can be enhanced by reference to the concepts of attachment theory and social cognition. Incorporation of these concepts into current care practices and future service development may improve the inpatient experience.

Introduction

Preventing inappropriate readmissions and promoting recovery among people who receive inpatient psychiatric care are explicit policies of the National Health Service (NHS) in Scotland (Scottish Executive, 2006, 2007). Developing understanding of how patients experience and adjust to inpatient care may help to ensure that patients are appropriately and adequately supported around discharge, and facilitate implementation of these policies.

Mental health policy recommendations frequently reference service user surveys (e.g. Scottish Executive, 2007), but these are subject to limitations. For example Simons, Petch and Caplan (2002) interviewed former inpatient service users across eight Scottish health boards. The schedule was comprehensive, but highly structured with closed questions and a practical focus. The resulting data reflect this. It is known that less than half of interviewees were fully satisfied with the discharge process. It is not known if or how this circumstance affected perceived wellbeing or functioning. Conversely the Highland Users Group, a network of service users, published in 2003 findings of a members' survey. Comments clearly illustrate an emotional response to discharge (e.g. "You can feel cast out without even a goodbye and you can feel very apprehensive" p.7), but the report is descriptive and does not extrapolate from individuals' comments to a broader understanding of the discharge experience.

This study aimed to develop understanding of the inpatient care and discharge experience from the perspective of service users, not survey developers, by combining thematic analysis of detailed individual accounts with measures of psychosocial constructs understood to be associated with adjustment following an episode of acute mental illness.

Method

Design

This project employed an embedded mixed methods design, wherein the primary qualitative methodology, thematic analysis, was supplemented by standardised assessment of sensitising concepts, providing an additional means of validating themes and permitting triangulation within extant theory (Cresswell & Plano-Clark, 2007).

Participants

Ethical and management approval for the project was obtained from local ethics and governance committees. The research setting was a 26-bed NHS inpatient mental health unit, serving adults in the acute phase of mental illness or undergoing detoxification from substance abuse. Patients were invited to participate by posters in the unit's communal areas, and discussion at the weekly community group. All patients who were resident for seven or more days were eligible, providing they were deemed capable of consenting by their admitting doctor. Individuals indicating interest in participation were given detailed information, opportunity to ask questions and time to reflect before written consent was sought. Twelve patients consented to take part. Their characteristics are summarised in Table 1.

<insert table 1 about here>

Data gathering

The principal mode of data collection was by individual, face-to-face interview. Each participant gave two interviews, one at time of discharge, and one approximately four weeks post-discharge (note that one participant was unavailable for follow-up interview). Interviews were semi-structured, i.e. while initial questions indicated *a priori* areas of interest, participants were encouraged to expand on points arising and detailed probe questions were generated *ad hoc*. Interview schedules evolved as themes were identified and elaborated, latterly incorporating 'member checking'; asking participants to comment on the developing analysis. Interviews were conducted and transcribed (from audio recording) by the first author.

Standardised measures were completed at first interview. These were selected to assess a range of factors previously associated with adjustment to acute mental illness; symptoms of anxiety and depression (e.g. Huppert, Weiss, Limm, Pratt & Smith, 2002); social support (e.g. Troister, Links & Cutliffe, 2008); adult attachment style (e.g. Grunebaum et al. 2009; Tait, Birchwood & Trower, 2004) and negative appraisal of mental illness (e.g. Karatzias,

Gumley, Power & O'Grady, 2007). Specific measures were selected for brevity and face validity.

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). Participants rate severity of sixteen cognitive and somatic symptoms of anxiety and depression.

S*ignificant Others Scale* (SOS; Power, Champion & Aris, 1988). Participants identify seven close relationships and rate actual and ideal support from each across four support domains; sharing feelings, practical support, times of difficulty and social time.

Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994). Participants rate 30 statements about close relationships, generating dimensional scores on four attachment styles; secure, dismissing, fearful and preoccupied.

Personal Beliefs about Illness Questionnaire (PBIQ; Birchwood, Mason, MacMillan & Healy, 1993). Participants rate agreement with sixteen negative belief statements in five domains; loss, humiliation, shame, attribution of behaviour to self or illness and entrapment.

All measures had previously been demonstrated valid with comparable clinical samples (e.g. Baynes et al., 2000; Bjelland, Dahl, Haug & Neckelman, 2002; Ma, 2006; Sherwood, Salkovskis & Rimes, 2007).

Analysis

Interview data were subject to thematic analysis within a social constructivist framework), an epistemological stance emphasising the active role of the researcher in constructing and interpreting themes. Line-by-line coding was conducted with early interviews, and clustering of initial codes indicated that choice, engagement and making sense of illness were salient to participants. Subsequent interview schedules were modified to elaborate properties and dimensions of developing themes and analyse interrelations. Constant comparison between early interview data, newly arising interview data and the coding structure led to an iterative process of de/reconstructing themes until the structure was understood to represent participants' experience with adequate depth and detail. A series of memos recorded descriptions, reflections and analytical queries about the developing codes and structure. Analysis was supported by the software NVivo 8 (QSR International 2008) and analytical rigour was enhanced by the maintenance of an audit trail and reflective journal, and ongoing consultation with participants, colleagues and supervisors.

Qualitatively derived themes were integrated with quantitative data, using a variant of a process described by Glaser and Strauss (1967). For each theme, participants were divided into those who were 'significant contributors' (i.e. their narratives had make frequent or notable reference to the theme) and those who were not. The two groups were then compared in terms of their responses to standardised assessments. These comparisons informed the literature review. For example, RSQ ratings differed between significant and non-significant contributors to 'problem patterns' theme, suggesting problem patterns may be interpretable within an attachment framework (note that in accordance with Glaser & Strauss (1967) the definition of 'significant contribution' and magnitude of 'significant difference' were judged subjectively). A review of the literature concerning attachment and mental health supported this, and comparisons with prior findings were discussed. Many comparisons yielded no significant difference (or absence of difference) which was interpretable in the context of extant literature, consequently only a small proportion of the total comparisons are presented in the results.

Results

The central theme of participants' experience is *facing choices*. Analysis generated 14 constructed themes, with 22 subthemes. These are discussed in the sequence they typically arose in the narratives, though it is emphasised that the progression is not entirely linear. A schematic diagram (Figure 1) illustrates relationships between categories. Note that *italicised* phrases indicate category titles.

<insert Figure 1 about here>

The themes *being coherent, having control, unwanted wants* and *dangerous defaults* were constructed from participants' accounts of acute mental illness. Coherence refers to one's perceived capacity to make reasoned choices. Participants describe 'turmoil', 'madness' and 'hysteria' which obstruct this. The experience can be so alien it amounts to a loss of self; 'I was starting to feel a bit...mad in myself. I wasn't feeling like me any more' (Fiona). Control is the ability to implement one's choices. Losses of control 'spiral' or 'snowball' over time, despite resistance. Diminished coherence and control lead to *problem patterns*. Unwanted wants are thoughts or actions which would be objectionable when participants are

well. These can be transient or persistent, and two or more opposing desires - for example to die and to be kept safe - can be held simultaneously or sequentially, resulting in contradictory or chaotic behaviour. Dangerous defaults, such as social withdrawal, are defined by the sense that one's natural inclinations are a threat to wellbeing; a 'slippery slope'.

Descriptions of emotional volatility, impulsivity and loss of self in these themes suggest participants are experiencing impaired mentalisation: the process of adaptively attending and responding to mental states in oneself and others. Mentalisation 'underlies the capacities for affect regulation, impulse control, self-monitoring and the experience of self-agency – the building blocks of the organisation of the self' (Fonagy, Gergely, Jurist & Target, 2005, p.25). It is grounded in attachment theory. Theoretically, securely attached adults have internal working models of themselves and others as valued, autonomous beings, and their interpersonal narratives are marked by sensitive, balanced and flexible mentalisations. Insecurely attached individuals lack such positive models and their mentalisations comprise superficial preoccupation with negative attachment experiences (anxious attachment) or denigration of emotional experiences (avoidant attachment; Lopez, 2009). Where mentalisation has been operationalised as reflective functioning (Fonagy, Target, Steele & Steele, 1998) this hypothesised relationship has been empirically demonstrated (e.g. Bouchard et al., 2008).

The interpretation of these themes as impaired mentalisation is supported by standardised assessment. Significant contributors to coherence, control and unwanted wants rated themselves more highly for fearful attachment. Significant contributors to dangerous defaults, rated themselves more highly for dismissing attachment. Quality of narratives also indicated impaired mentalisation. While some participants spontaneously offered complex, reflective narratives, others appeared unwilling or unable to reflect in detail on recent experiences, employing strategies to divert attention from internal events, e.g. intellectualising emotional accounts or shifting topic. Laithwaite and Gumley noted similar narrative limitations in their interview study of forensic inpatients (2007).

Perceiving their own mental states and actions as potentially harmful, participants describe pervasive feelings of *fear* and *guilt*. These themes function as *both* cause and consequence of events during this period and are represented in the diagram as underlying conditions. Significant contributors to these themes scored higher on HADS anxiety and depression

subscales. For fearful, guilty participants the *function of the ward* is to restrict choice - it will not let you do what you 'want', it will not let you slip down your slope.

The ward does this by *creating boundaries*. It limits access to implements or substances to abuse. Proximity of staff limits erratic behaviour, and is containing. The sub theme of *ward as a bubble* is a special instance, creating boundaries between the person and external stressors, creating 'space'. The ward also functions by *moulding you back into shape*. There are therapeutic interventions, nurturing and 'coaching' from staff and fellow patients. The ward routine promotes more adaptive functioning and this can become self-sustaining.

These conceptualisations of the function of admission align with others in the qualitative literature. Thomas, Shattell and Martin (2002) found "the essential meaning of the ward for psychiatric patients was a refuge from self-destructiveness" (p.101), while Hummelvoll and Severinsson (2001) found the principal needs of inpatients were respite, and meaning making: being set on 'a new track' (p.21). Bowers, Chaplin, Quirk and Lelliot (2009), synthesising qualitative and quantitative research and policy documents, generated a model of acute inpatient psychiatry. Their themes 'containing'; the redefining and enforcement of boundaries between self and others and self and objects, and 'presence+'; the availability of benevolent support to attain/regain functioning, are analogous to boundaries and moulding.

Given the recurring themes of containment and regulation, there are notably few relationships between function themes and attachment subscales. Significant contributors to creating boundaries scored more highly on fearful and dismissing subscales, indicating high attachment avoidance, which may be in keeping with a crisis response which seeks boundaries between self and stressors. However, no relationships were seen between attachment and the themes ward as a bubble or moulding back into shape, i.e. participants who contributed to these themes scored no differently than those who did not. Significant contributors to both themes were more likely to endorse PBIQ statements indicating lack of personal control over illness, which might be consistent with seeking external control, but there were no other consistent trends in illness appraisal. It may be that the close alignment to existing studies can explain this: if what patients seek is universal there is no reason to hypothesise between-group differences.

Though the ward is protectively restrictive, participants still have choices prior to and during admission and these are highly valued. However the theme *having choices* illustrates that the relationship between the presentation of a range of options and the understanding of having meaningful choices is not straightforward. For example, though all participants were 'voluntary' admissions, *all* described being admitted by necessity not choice – choice is restricted by fear:

...anyone who understands my care plan knows hospital for me is the last resort. I hate going to hospital. [##R## Mmm hmm.] I only go to hospital if it's life or death. (Henry)

A further constraint on choices is *moral obligations*; participants' sense of how they 'should' engage with services. Parsons' (1978) conceptualisation of the sick-role is relevant. Parsons proposed that the 'sick' are exempted from blame for their condition and from normal social responsibilities. In return, they are obliged to seek and adhere to professional advice to get 'better'. Parsons viewed the professional/patient relationship as quasi-parental. It is therefore notable that there were no relationships between attachment subscales and these themes.

There is an important discrepancy between Parsons' sick role and current findings: many participants *do* perceive themselves as to blame for their illness. Consequently their inability to meet responsibilities is associated with inadequacy not relief, and their moral obligations are driven by guilt and shame rather than positive pursuit of wellness. Studies using the PBIQ or similar measures suggest that shame, humiliation and reduced social status are prevalent perceptions among people experiencing mental illness (e.g. Birchwood, Iqbal, Chadwick and Trower, 2000). In a grounded theory study, van Vliet (2010) identified links between shame and perceptions of control: in a shaming situation one is to blame for the problem, but not in control of the solution. Significant contributors to moral obligations themes indicated lower perceived control over illness on the PBIQ.

Three continuous themes represent participant accounts of engaging with staff; *co-operating*, in the sense of working jointly; *cooperating*, in the sense of being compliant; and *being uncooperative*. Co-operating occurs where patient and staff views are both openly available and respected, such that choices are informed by – if not perfectly suited to – both parties. Cooperating - acquiescing to suggestions while offering little input - is the most commonly

described interaction pattern. Cooperation is driven by fear, hope, and not knowing what else to do. Feeling a moral obligation to engage is also associated with cooperation, one being effectively the behavioural manifestation of the other.

Several strategies of cooperative interaction were described. Participants allow *decisions to be made on their behalf*, and then *assimilate the views* of the decision-maker. One has a sense that this serves to reduce dissonance where an undesired decision has been made. Cooperation may take place because participants hold no strong personal views. Apathy was repeatedly identified as an aspect of diminished coherence:

> Being in [the ward], it didn't mean anything, it's just a place. You're so preoccupied with your own thoughts and mind [##R## Right.] that you didn't notice where you were. (Gillian)

Guess, Benson and Siegel-Causey (2008) identified the prerequisites of choice as a say, options and a preference. Participants in this project were sometimes unable to identify preferences. This may not be unusual: Fleischmann (2003) found that 1 in 5 people at admission swere satisfied to leave treatment decisions to their doctor.

Some participants though, hold opposing views but elect *not to communicate,* most commonly to avoid conflict when their distress tolerance and sense of control is fragile. Closely linked is *resigning oneself,* which can be a positive process of letting go of anger and frustration, but can itself be an angry and frustrated act. Birchwood et al. (1993) drew a similar distinction between acceptance of diagnosis of mental illness as a passive conforming or active integrating act. At the extreme of cooperation are those participants for whom '*doing what I'm told'* holds an almost talismanic ability to ward off relapse.

There is increasing literature linking attachment theory to engagement and treatment choices. Insecure attachment has been associated with less help-seeking, less self-disclosure and poorer treatment use (Dozier, 1990); poorer ratings of therapeutic alliance by patients and staff (e.g. Berry, Barrowclough & Wearden, 2008); and greater likelihood of disengaging from services (Tait et al., 2004). One hypothesised basis is internal working models of care-givers (Bowlby 1973); therapeutic relationships are most effective when secure attachment allows individuals to disclose needs without feeling vulnerable and perceive others as reliably able to meet them. The findings of standardised assessment are consistent with this.

Significant contributors to co-operation had lower scores for fearful attachment, and marginally lower scores for preoccupied and dismissing styles, while significant contributors to cooperation had higher scores for secure and lower scores for fearful, preoccupied and dismissing styles. Scores on the PBIQ expectations subscale which includes statements such as 'I will always need to be cared for by professional staff' were higher among significant contributors to co-operative and cooperative engagement, which may indicate positive models of staff as able to meet one's needs.

The theme *trying to understand staff actions* suggests an alternative attachment-derived interpretation. Participants made explicit reference to trying to comprehend the reasoning underlying staff decisions:

> You know you evaluate; what choices do I have? [##R## Mmm.] Em, what expertise does this person have? You know what knowledge do they have? Why am I going to follow this person em, into that situation? (Jack)

This indicates reasonably sophisticated mentalisation; internally representing qualities, intentions and motives of self and other. It is likely that this is much more challenging at times of attachment crisis. Standardised assessments support this interpretation. Significant contributors to this theme, i.e. most explicitly reporting functional mentalisation, scored slightly higher on the secure subscale of the RSQ, and lower on insecure attachment subscales, particularly the dismissing style.

Many authors have suggested that mental health staff or services meet attachment needs when stressors or the stress of illness have initiated attachment behaviours (e.g. Adshead, 1998), and the themes *being available*, *being genuine*, and *being competent* are easily interpretable as the attributes of an ideal attachment figure (Bowlby, 1969). It is surprising therefore that there was only one relationship between these themes and attachment styles: significant contributors to being available scoring lower on preoccupied attachment. Interview data offer one possible explanation. The theme *developing a trusting relationship* indicates that for some participants trusting staff is default, while for others trust has been earned by consistent demonstration of positive attributes. The latter group score higher for fearful and dismissing attachment, but still evaluate staff positively, suggesting that staff have – at least temporarily – overcome avoidant internal working models. A current question is whether patients form attachments to staff members, to teams, or to institutions (e.g. Ma,

2007; Catty et al., 2011). Staff in this project were typically referred to as 'staff' without differentiation by name or by profession/grade, suggesting that it is the team or ward that is the locus of attachment.

Negative interactions occur when staff are perceived to be *violating the trust relationship*, by being rejecting, blaming or critical. Participants respond by *being uncooperative*. This theme represents situations wherein participants' thoughts or behaviours conflict with those of staff. Un-cooperative behaviour is typically driven by fear. For example Henry feels compelled to risk-taking behaviour because a refusal to admit him amounts to a rejection which puts his life at risk. It is no challenge to interpret this as a hyperactivating strategy intended to bring about proximity to the attachment figure. In a focus group study Lester, Tritter and Sorohan (2005) found that both patients and GPs reported exaggerating symptoms to access secondary care. It is unsurprising that significant contributors to being uncooperative also report more fearful and dismissing attachments. It is also noteworthy that some participants feel able to be uncooperative but not inclined, while others feel inclined to be uncooperative but not able. The latter group indicate more preoccupied attachment, consistent with a state of mind which is too fearful of rejection to contest others' views.

The preceding themes are interpreted as indicating that admission, by means of a containing environment and responsive relationships, is meeting attachment needs of patients in crisis. Correspondingly *being discharged* may be interpretable as a separation event, instigating reactivation of threat systems, decreased mentalisation and implementation of attachment strategies (e.g. Adshead, 1998; Goodwin, 2003). Aspects of participant accounts of being discharged accord with this. Participants express intense, mixed emotions; gratitude, and hope, but also guilt and apprehension. For some there is intense fear, protest, and renewed help-seeking

Being discharged – even for participants with multiple prior admissions – is a period of self-reflection, of *making sense of illness*. Each patient understands him or herself as *being vulnerable,* to stressors and to relapse. Significant contribution to being vulnerable was associated with higher ratings of depression, more fearful attachment style, and greater identification with self as illness on the PBIQ, all consistent with an internal working model of self as unable to depend on one's own inadequate resources. Being vulnerable means *being limited or impaired*; participants may relapse at any time, they may cause relapse by

'doing too much'. Consequently they face a future of restricted geographical, economic, social and romantic possibilities. Significant contribution to this theme was associated with higher ratings of anxiety and depression, and increased identification of self as illness. There was an unexpected finding that significant contributors indicated less concern about control over illness, which may reflect a sense that illness can be controlled *by* limitation.

'*Am I ever going to feel really well again*?' collates participants' negative beliefs about the likely course of their vulnerability and impairment. Unsurprisingly, signficant contribution to this theme was associated with a greater identification as self as illness on the PBIQ. It was also associated with increased depression, and it is plausible that pessimism is a manifestation of depression. However negative beliefs about illness have been associated with hopelessness (White, McCleary, Gumley & Mulholland, 2007) and lower status of anticipated future self (Iqbal, Birchwood, Chadwick & Trower, 2000) when current depression is controlled for.

In the theme *judging (my) mental illness*, participants considered the place or value of people (including themselves) with mental illness in a wider social context. Some but not all participants expressed negative self-judgements, e.g. that their illness was a manifestation of personal weakness. Some but not all people anticipated these judgements from other people. Unexpectedly contribution to this theme was not associated with beliefs about stigma or social containment on the PBIQ, nor was it associated with attachment scales, despite identification of self as flawed and others as critical or rejecting.

Patients' beliefs about their illness have been empirically linked to depression, hopelessness and impaired functioning (Birchwood et al., 2000; White et al., 2007; Broadbent et al., 2008). In these interviews we have seen how experience and evaluations of impairment lead participants to be fearful of choices, to seek restriction of choices, to turn choices over to others and to consider future choices as limited. It is likely that these perceptions will impact both the subjective experience and the objective outcomes of the post-discharge period.

Discussion

By comparing themes constructed from detailed accounts with existing literature, and supplementing these comparisons with reference to standardised assessment, this project has

demonstrated that constructs from attachment theory and illness appraisal literature play a role in participants' conceptualisation of inpatient care and discharge.

As well as illustrating the utility of existing constructs, this project has highlighted opportunities to extend current thinking. Though there has been much theoretical discussion of mentalising, there has been little describing how impaired mentalisation is *experienced* in response to attachment threat. Though this project adds to that literature in only a limited way, it does demonstrate that a phenomenological approach can generate new avenues of interest. For example the suggestion that engagement with services may vary with clients' ability to mentalise staff intentions has not, to the best of the authors' knowledge, been previously considered.

A central tenet of attachment theory is that the attachment system is activated when an individual is 'frightened, tired or ill' (Bowlby, 1969, p.371). Existing research has examined impaired mentalisation and affect dysregulation as *consequences* of perceived threat. These narratives suggest they are *themselves* threatening. Loss of coherence and control is intensely frightening. Accessing support is exhausting, and exposes one to potential rejection. The 'frightened, tired' individual becomes more frightened, more tired. Mikulincer, Shaver and Pereg (2003) have suggested that chronic attachment system activation generates a 'self-amplifying cycle of distress' (p.85) because absorption in attachment activities leaves one vulnerable to new stressors. I suggest an alternative hypothesis: distress is 'self-amplifying' because its consequence – dysregulation – is itself distressing.

Though the PBIQ has predominantly been used with samples with diagnoses of psychosis, the identification of relationships between PBIQ ratings and participant experience in this mixed sample suggests that its constructs may be 'transdiagnostic'. That some themes were related to measures of attachment *and* illness beliefs is not problematic: the two theories are not mutually exclusive, indeed may be compatible if one conceptualises negative beliefs about self and illness as part of a negative working model of self.

A small number of relationships were found between constructed themes and measures of psychopathology and social support, however these did not signify any coherent explanatory framework. In an exploratory project where multiple measures were selected to be wide-ranging it was highly unlikely that all would prove theoretically relevant. Thus the absence

of consistent associations with these measures is not necessarily a threat to the validity of constructed themes. Notably, the themes concerning moral obligations did not clearly align with any theoretical framework. Because the concept of moral obligations in this context is as yet poorly understood but clearly salient to participants, we highlight this for future research.

The project was subject to methodological limitations. The recruitment strategy precluded theoretical sampling. As the thematic structure developed it would have been valuable to interview, for example, an individual admitted under section. No such individual came forward and consequently there are significant gaps within and between themes. As such findings cannot properly be referred to as a grounded theory. Rather they should be regarded as preliminary, descriptive categories which should initiate further research both qualitative and quantitative.

With these caveats in place we consider the practical implications of these findings. The day-to-day management of individual patients may be enhanced by greater awareness among ward staff of issues of attachment and illness appraisal. For example, staff should be aware that patient 'choices' may be made in response to short term attachment needs rather than 'rational' long-term goals, and should endeavour to satisfy the former without compromising the latter. Careful consideration should be given to how, and crucially by whom, choices are presented, as it is likely that they will be perceived differently depending on the evaluation of the presenter in attachment terms.

Choice and control are dominant themes in the recovery movement (Bonney & Stickley, 2008; Bradstreet 2004) and service user surveys consistently find that patients want more choice and control in their treatment (Simons et al. 2002). Within this literature there is typically an equation of the 'traditional' patient role with submission to a controlling paternalistic system and a call for reform (e.g. Colombo, Bendelow, Fulford & Williams, 2003). Yet respondents in this study took a different tone: their choices are sometimes restricted, but they are not necessarily dissatisfied with this. Attachment theory can make sense of this: the ward is functioning as a safe haven, provided it does so in a flexible and individualised way, containment and protective restraint are what is wanted.

This project contributes to a growing body of literature indicating that people with mental health problems look to services to meet attachment needs (e.g. Goodwin, 2003; Ma, 2007). The inpatient setting, which offers a secure physical environment and continuous staff presence, is uniquely fitted to meeting these needs (Bowers et al. 2009). Yet mental health policies consistently undermine their capacity to do so (Blackburn et al. 2010; Catty et al. 2011; Goodwin, 2003; Hummelvoll & Severinsson, 2001).

For example, commitment to reducing inpatient readmissions (Delivering for Mental Health, 2006), ultimately necessitates raising the threshold for admissions. The admission decision is one example of a fundamental tension between mental health policies and the recovery approach. Recovery models indicate that patients have a responsibility to request appropriate support when needed (e.g. Broadbent et al. 2008, Jacobson & Greenley, 2001). Yet a gatekeeping stance to service provision responds to requests for support with a demand for proof of need; inevitably playing into the kind of escalation strategies noted in this study and others (e.g. Lester et al. 2005). Tait et al. (2004) characterised an attachment-sensitive service as 'on tap but not on top' (p.414), available and responsive, but leaving patients in control. It is almost impossible to reconcile this with current policies about service access.

One means of approaching the conundrum is to reconsider the way in which inpatient care serves attachment needs. Inpatient care functions as a safe haven (e.g. Laithwaite & Gumley, 2007; Thomas et al., 2002) and is valued as such (though Lelliot & Quirk (2004) have less charitably described it 'a non-therapeutic dumping ground', p.297). The ideal attachment relationship however, functions not only as a safe haven, but as a secure base from which to explore and develop (Bowlby, 1969). Mikulincer et al. (2003) observed that from a safe base one can 'broaden and build' one's own resources, but this can only take place after relief is obtained and security is restored.

It may be possible to enhance inpatient care to accomplish this. By respecting patients' requests for admissions without reinforcing safety behaviours; by providing sustained encouragement from respected sources and mastery experiences (both facilitate the development of self-efficacy, central to recovery; Mancini, 2007); by managing delayed discharges better such that the ward does not become a holding pen for indefinite periods, and by the provision of formal psychological therapy with a mentalising focus, the ward may promote self-regulation and ultimately undermine need for its containing function.

Practitioner Points

- Mental health staff should be aware that patient 'choices' may be made in response to short term attachment needs rather than long-term goals, and should endeavour to satisfy the former without compromising the latter.

- Service planning must take into account issues of attachment and illness beliefs if tensions between the recovery approach and mental health policies are to be resolved.

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Table 3.1: Sample characteristics

Participant	Pseudonym	Gender	Age	Reason for admission (self-defined)
A	Angela	Female	30-39	Complex care plan
B	Brian	Male	60-69	Depression/anxiety
C	Colin	Male	50-59	Depression
D	Derek	Male	50-59	Depression/emotional distress
E	Ellie	Female	40-49	Alcohol detox
F	Fiona	Female	18-29	Depression
G	Gillian	Female	40-49	Hypermania
H	Henry	Male	30-39	Mania/suicidality
I	Isla	Female	50-59	Depression
J	Jack	Male	30-39	Attempted suicide
K	Ken	Male	50-59	Schizophrenia
L	Linda	Female	50-59	Depression/suicidality

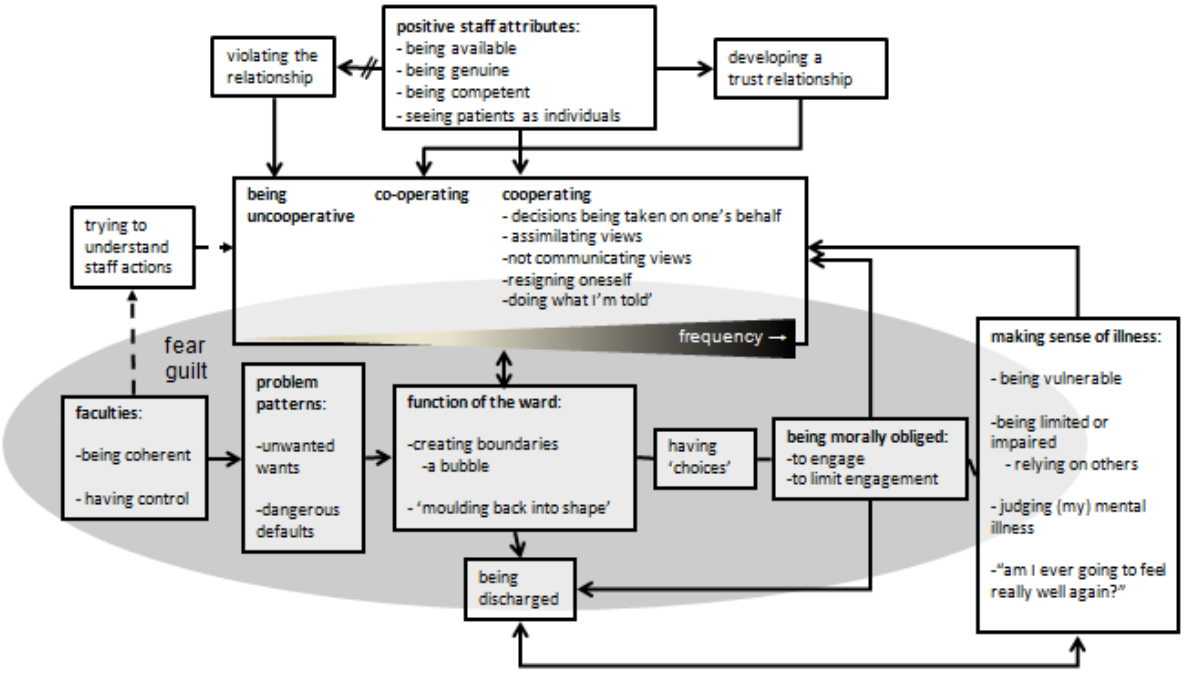

Figure 1: Schematic diagram of constructed themes.

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List of appendices

Appendix 1: Instructions for contributors, Psychological Medicine.

CAMBRIDGE | Instructions for Contributors

Psychological Medicine

Editorial Policy

Psychological Medicine is a journal aimed primarily for the publication of original research in clinical psychiatry and the basic sciences related to it. These include relevant fields of biological, psychological and social sciences. Review articles, editorials and letters to the Editor discussing published papers are also published. Contributions must be in English.

Submission of manuscripts

Manuscripts should be submitted online via our manuscript submission and tracking site, http://www.editorialmanager.com/psm/. Full instructions for electronic submission are available directly from this site. To facilitate rapid reviewing, communications for peer review will be electronic and authors will need to supply a current e-mail address when registering to use the system.

Papers for publication from Europe, (except those on genetic topics, irrespective of country), and all papers on imaging topics, should submitted to the UK Office.
Papers from the Americas, Asia, Africa, Australasia and the Middle East, (except those dealing with imaging topics), and all papers dealing with genetic topics, irrespective of country, should be sent to US Office.
Generally papers should not have text more than 4500 words in length (excluding abstract, tables/figures and references) and should not have more than a combined total of 5 tables and/or figures. Papers shorter than these limits are encouraged. For papers of unusual importance the editors may waive these requirements. Articles require a structured abstract of no more than 250 words including the headings: Background; Methods; Results; Conclusions. The name of an author to whom correspondence should be sent must be indicated and a full postal address given in the footnote. Any acknowledgements should be placed at the end of the text (before the References section).
Declaration of Interest: A statement must be provided in the acknowledgements listing all financial support received for the work and, for all authors, any financial involvement (including employment, fees, share ownership) or affiliation with any organisation whose financial interests may be affected by material in the manuscript, or which might potentially bias it. This applies to all papers including editorials and letters to the editor.
Contributors should also note the following:
1. S.I. units should be used throughout in text, figures and tables.
2. Authors should spell out in full any abbreviations used in their manuscripts.
3. Foreign quotations and phrases should be followed by a translation.
4. If necessary, guidelines for statistical presentation may be found in: **Altman DG., Gore SM, Gardner, MJ. Pocock SJ.** (1983). Statistical guidelines for contributors to medical journals. *British Medical Journal* **286**, 1489-1493.

References

(1) The Harvard (author-date) system should be used in the text and a complete list of References cited given at the end of the article. In a text citation of a work by more than two authors cite the first author's name followed by *et al*. (but the names of all of the authors should be given in the References section). Where several references are cited together they should be listed in rising date order.

(2) The References section should be in alphabetical order. Examples follow:
Brown GW (1974). Meaning, measurement and stress of life events. In *Stressful Life Events: Their Nature and Effects* (ed. B. S. Dohrenwend and B. P. Dohrenwend), pp. 217-244. John Wiley: New York.
Brown J. (1970). *Psychiatric Research*. Smith: Glasgow.
Brown J, Williams E, Wright H (1970). Treatment of heroin addiction. *Psychological Medicine* **1**, 134-136.
Note: authors' names should be in **bold** font; journal titles should always be given in full.

(3) References to material published online should follow a similar style, with the URL included at the end of the reference, with the accession date, if known. Authors are requested to print out and keep a copy of any online-only information, in case the URL changes or is no longer maintained. Examples follow:
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British Psychological Society Research Digest, Issue 12.
(http://lists.bps.org.uk/read/messages?id=1423). Accessed 17 February 2004.

Figures and tables

Only essential figures and tables should be included and should be provided in black and white except in exceptional circumstances, eg PET scan images etc (Please note that costs for unnecessary colour figure reproduction will be passed along to the author). Further tables, figures, photographs and appendices, may be included with the online version on the journal website.
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All graphs and diagrams should be referred to as figures and should be numbered consecutively in Arabic numerals. Captions for figures should be typed double-spaced on separate sheets. Tables should be numbered consecutively in the text in Arabic numerals and each typed on a separate sheet after the References section. Titles should be typed above the table.

Proofs and offprints

Page proofs will be sent to the author designated to receive correspondence. Corrections other than to printer's errors may be charged to the author. Authors will automatically receive a PDF of their article as soon as the issue in which it appears is published.
(Revised 23/01/11)

Appendix 2: Author Guidelines, Psychology and Psychotherapy: Theory, Research and Practice.

Psychology and Psychotherapy: Theory, Research and Practice

Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

6. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the

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11. The Later Stages

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12. Early View

Psychology and Psychotherapy is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document. What happens to my paper?

Initial Interview Schedule

Introduction to the interview

- Reiteration of study aims and process
- Socialisation to interview (e.g. please give as much information as you would like, I can ask questions but I want to hear *your* thoughts)
- Checking for consent and questions

How did you come to be in Huntlyburn?

- What was happening in your life before your admission?
- What/who was involved in the decision to come to Huntlyburn?
- What (if any) concerns or hopes did you have before you came in?

What has it been like for you to be in Huntlyburn?

- Has it been how you had imagined or expected?
- What (if anything) has been especially positive or negative about the experience?

What are your thoughts about your approaching discharge?

- About the timing?
- About the planning?
- What emotional effects has it had?

What hopes or concerns do you have for the next few weeks?

- How will you deal with these?
- Who (if anyone) will help you, and how?
- How optimistic do you feel about this period?
- How will you know how things are going?

Conclusion to the interview

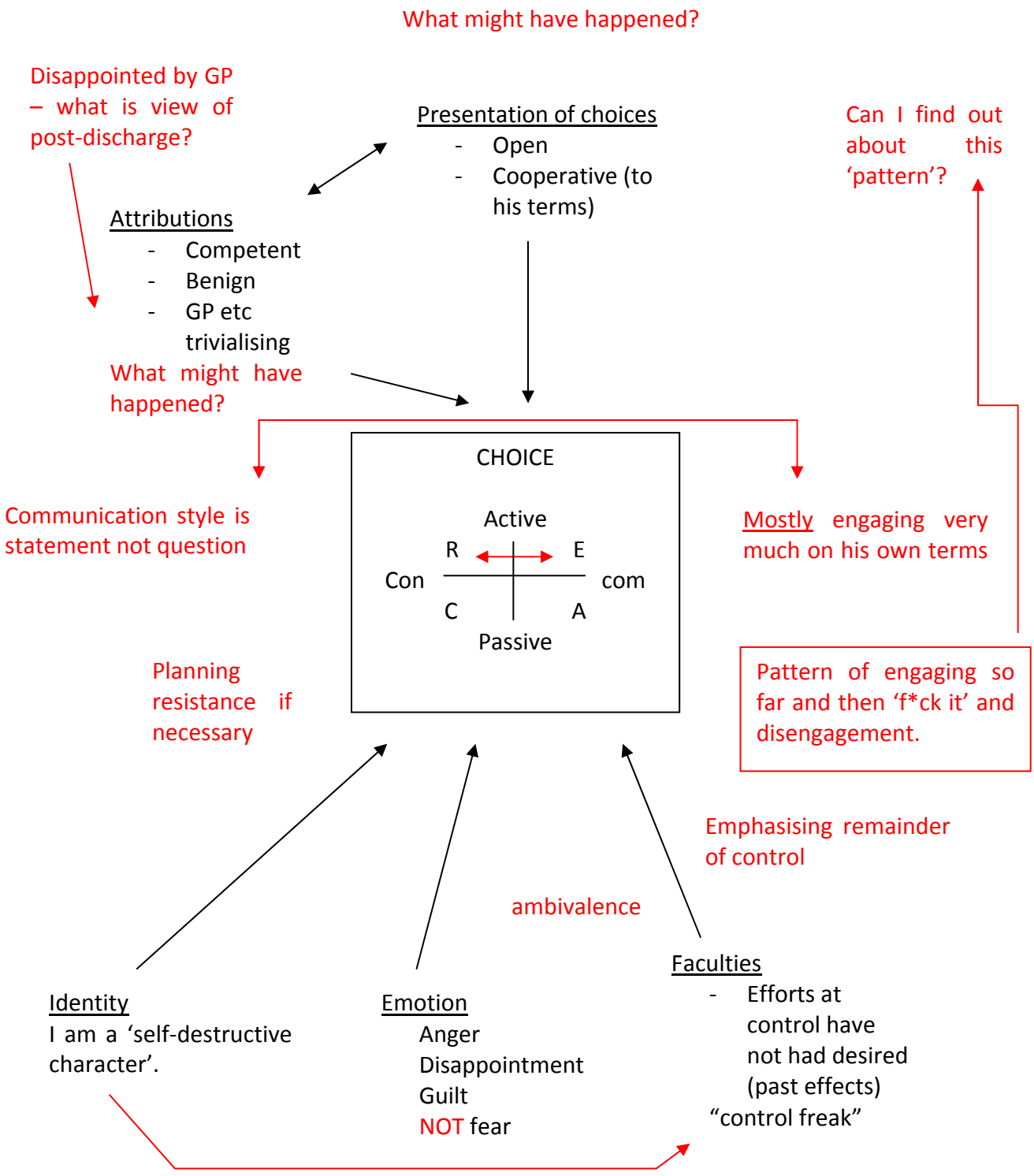
- Is there anything that I should know that I haven't asked about?
- Is there anything that you would like to ask me?

General prompts (for use throughout the interview)

- Can you tell me a bit more about that?
- Can you explain what you mean by X?
- What did it mean to you when X happened?

If you have any questions about this study before, during or after participation, please contact Jenny Strachan (Trainee Clinical Psychologist) on 01896 668821 or at Jennifer.Strachan@borders.scot.nhs.uk)

J2 12/4/11



- Can I unpack what was going on when he went to the front desk?
- You want to be in hospital, but if they tried to keep you in you'd try to break out?
- Are there ever examples of compliance?/e.g.

NB – others don't frame it as compliance?

Appendix 4: Example memo (initially handwritten but typed for clarity).

Is this trite? Obviously discharge is the handover of responsibility * Is it worth looking into how this is constructed?

GO BACK TO DATA & TEST

Responsibility 24/1/11

* What about the CMHTs? Legal? Moral? Practical? e.g. 'friend X'

Is the (formal*) handing over of responsibility actually what happens at admission/discharge?

- H is not 'threatened' by disbelief or rejection. He is overwhelmed by responsibility – he needs to be admitted when 'his sister can't cope' – are his escapades a need to prove how irresponsible he is, to make them take over?
  - What is happening when the ward refuses to section?
- G described herself literally as a 'management issue' – to be admitted when she can't 'manage'
- F needed a break from 'adult' responsibilities 'I'm only 20' frightened when they were all still there to be handed back wholesale.
- C enthused by discharge plans – more changes and responsibilities

B – can be collaborative eg family looking for cues.

Relative needs of other patients = younger siblings?

Passivity = infancy recovery = adolescence?

B & C – wifes have responsibility.

→ Links in with the identity/aberration thing – I am capable but I need help or rest vs. I am not capable.

* hence the 'midway' status of passes?

? staff have knowledge they retain control

Personal reflection – I have come at this with the 'assumption' that control is desirable and in itself controllable. "abdication"

Critical language

with great power comes great responsibility"
nd vice versa what if you cannot trust ourself to wield power safely?

Knowledge is power.

Is power offered up or seized ? passed back or dumped?

Can feel safe and staged or dumped on.
Negotiation?

Appendix 5: Standardised assessment pack.

Experience of discharge from Huntlyburn

D Clin Psy Thesis 2010, Jennifer Strachan, Trainee Clinical Psychologist

Standardised Assessments

Participant Code:

Thank you for agreeing to take part in this study. This questionnaire pack forms part 1 of the study. Please fill in the requested details below (if you would prefer me to find this information in your notes, please tick here □). Then read each of the four questionnaires and complete them carefully. If you would like any help, or have any questions, please contact me. *You are free to leave out any questions that you are not happy to answer*.

Age: 18-29 □ 30-39 □ 40-49 □ 50-59 □ 60-69 □ 70+ □

Gender: Male □ Female □ Other □

Reason for admission: _____

Length of admission: _____ weeks _____ days

Number of prior admissions: (in last 3 years) 0 □ 1 □ 2 □ 3 □ 4+ □

Total time admitted: (in last 3 years) _____ weeks _____ days

If you have any questions about this study before, during or after participation, please contact Jenny Strachan (Trainee Clinical Psychologist) on 01896 668821 or at Jennifer.Strachan@borders.scot.nhs.uk.

Hospital Anxiety and Depression Score (HADS)

This questionnaire helps your physician to know how you are feeling. Read every sentence. Place an "X" on the answer that best describes how you have been feeling during the LAST WEEK. You do not have to think too much to answer. In this questionnaire, spontaneous answers are more important.

A	**I feel tense or 'wound up':**	
	Most of the time	3
	A lot of the time	2
	From time to time (occ.)	1
	Not at all	0
D	**I still enjoy the things I used to enjoy:**	
	Definitely as much	0
	Not quite as much	1
	Only a little	2
	Hardly at all	3
A	**I get a sort of frightened feeling as if something awful is about to happen:**	
	Very definitely and quite badly	3
	Yes, but not too badly	2
	A little, but it doesn't worry me	1
	Not at all	0
D	**I can laugh and see the funny side of things:**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
A	**Worrying thoughts go through my mind:**	
	A great deal of the time	3
	A lot of the time	2
	From time to time, but not often	1
	Only occasionally	0
D	**I feel cheerful:**	
	Not at all	3
	Not often	2
	Sometimes	1
	Most of the time	0
A	**I can sit at ease and feel relaxed:**	
	Definitely	0
	Usually	1
	Not often	2
	Not at all	3

D	**I feel as if I am slowed down:**	
	Nearly all the time	3
	Very often	2
	Sometimes	1
	Not at all	0
A	**I get a sort of frightened feeling like "butterflies" in the stomach:**	
	Not at all	0
	Occasionally	1
	Quite often	2
	Very often	3
D	**I have lost interest in my appearance:**	
	Definitely	3
	I don't take as much care as I should	2
	I may not take quite as much care	1
	I take just as much care	0
A	**I feel restless as I have to be on the move:**	
	Very much indeed	3
	Quite a lot	2
	Not very much	1
	Not at all	0
D	**I look forward with enjoyment to things:**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3
A	**I get sudden feelings of panic:**	
	Very often indeed	3
	Quite often	2
	Not very often	1
	Not at all	0
D	**I can enjoy a good book or radio/TV program:**	
	Often	0
	Sometimes	1
	Not often	2
	Very seldom	3

The Significant Others Scale (SOS) (Power, Champion and Aris, 1988).

Listed below are various sources of personal and social support on which you may be able to draw. For each source of support please circle a number from 1 to 7 to show how well support is provided.
The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 to 7 to show what your rating is.
Please note: If a particular source of support does not exist for you, please leave the section blank.

Person 1.(state who).....

		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he or she give you practical help?	1	2	3	4	5	6	7
	b) What would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him or her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 2..(state who).....

		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does he or she give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with him or her socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 3...(state who).....

		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
3	a) Do they give you practical help?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
4	a) Can you spend time with them socially?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7

Person 4 .....(state who).....		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does this person give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with this person socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 5.(state who).....

1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
3	a) Does he or she give you practical help?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
4	a) Can you spend time with him or her socially?							
	b) What rating would your ideal be?	1	2	3	4	5	6	7
		1	2	3	4	5	6	7

Person 6..(state who).....		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Do they give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with them socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Person 7.....(state who).....		Never			Sometimes			Always
1	a) Can you trust, talk to frankly and share your feelings with this person?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
2	a) Can you lean on and turn to this person in times of difficulty?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
3	a) Does this person give you practical help?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7
4	a) Can you spend time with this person socially?	1	2	3	4	5	6	7
	b) What rating would your ideal be?	1	2	3	4	5	6	7

Relationship Scales Questionnaire

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships

		Not at all like me			Some-what like me			Very much like me
1.	I find it difficult to depend on other people.	1	2	3	4	5	6	7
2.	It is very important to me to feel independent.	1	2	3	4	5	6	7
3.	I find it easy to get emotionally close to others.	1	2	3	4	5	6	7
4.	I want to merge completely with another person.	1	2	3	4	5	6	7
5.	I worry that I will be hurt if I allows myself to become too close to others.	1	2	3	4	5	6	7
6.	I am comfortable without close emotional relationships.	1	2	3	4	5	6	7
7.	I am not sure that I can always depend on others to be there when I need them.	1	2	3	4	5	6	7
8.	I want to be completely emotionally intimate with others.	1	2	3	4	5	6	7
9.	I worry about being alone.	1	2	3	4	5	6	7
10.	I am comfortable depending on other people.	1	2	3	4	5	6	7
11.	I often worry that romantic partners don't really love me.	1	2	3	4	5	6	7
12.	I find it difficult to trust others completely.	1	2	3	4	5	6	7
13.	I worry about others getting too close to me.	1	2	3	4	5	6	7
14.	I want emotionally close relationships.	1	2	3	4	5	6	7
15.	I am comfortable having other people depend on me.	1	2	3	4	5	6	7
16.	I worry that others don't value me as much as I value them.	1	2	3	4	5	6	7

		Not at all like me						Some-what like me						Very much like me
17.	People are never there when you need them.	1		2		3		4		5		6		7
18.	My desire to merge completely sometimes scares people away.	1		2		3		4		5		6		7
19.	It is very important to me to feel self-sufficient.	1		2		3		4		5		6		7
20.	I am nervous when anyone gets too close to me.	1		2		3		4		5		6		7
21.	I often worry that romantic partners won't want to stay with me.	1		2		3		4		5		6		7
22.	I prefer not to have other people depend on me.	1		2		3		4		5		6		7
23.	I worry about being abandoned.	1		2		3		4		5		6		7
24.	I am somewhat uncomfortable being close to others.	1		2		3		4		5		6		7
25.	I find that others are reluctant to get as close as I would like.	1		2		3		4		5		6		7
26.	I prefer not to depend on others.	1		2		3		4		5		6		7
27.	I know that others will be there when I need them.	1		2		3		4		5		6		7
28.	I worry about having others not accept me.	1		2		3		4		5		6		7
29.	Romantic partners often want me to be closer than I feel comfortable being.	1		2		3		4		5		6		7
30.	I find it relatively easy to get close to others.	1		2		3		4		5		6		7

Personal Beliefs About Illness Questionnaire (PBIQ)

Initials ..... ID code .....

Date .....

	Strongly Disagree	Disagree	Agree	Strongly Agree
I will always need to be cared for by professional medical staff				
My illness frightens me				
I am embarrassed by my illness				
I am capable of very little as a result of my illness				
Because of my illness I have to rely on psychiatric services.				
There must always have been something wrong with me to have caused my illness				
I find it difficult to cope with my current symptoms				
My illness is too delicate/brittle for me to work or keep a job				
I know when I'm relapsing but I can't do anything about				
My illness is a judgement on me				
I am powerless to influence or control my illness.....				
I am fundamentally normal, my illness is like any other ...				
Society needs to keep people with my illness apart from everyone else.....				
There must be something about my personality that causes me to be what I am				
I can talk to most people about my illness				
There is something strange about me that causes my illness.				

Appendix 6: Poster

Hi, I'm Jenny Strachan, the trainee clinical psychologist on the ward, and I'm carrying out a research study.

I'm hoping to answer the question

'what's it like to be discharged from Huntlyburn?'

I'm inviting anyone who is about to be discharged to take part in some interviews about the experience.

If you think you might like to take part, you can ask your nurse for an information sheet. And/or you can speak to me directly. I'll be happy to answer any questions you have.

Many thanks

Appendix 7: Participant Information Leaflet

Experience of discharge from Huntlyburn
D Clin Psy Thesis 2010, Jennifer Strachan, Trainee Clinical Psychologist

Participant Information Sheet

Helping people who are discharged from mental health units to stay well and avoid another admission is an important target for the Scottish government. The NHS collects a lot of information about people who are discharged. For example we know how many people have a follow-up appointment arranged before they leave, and that transport is a problem for many people. What we don't know is what it is *like* for a person to be discharged from hospital. I believe that if we understand better how people think and feel about their discharge, what changes they have to make and how they choose to cope, we can support people better.

This is why I am inviting you to take part in a study about the experience of being discharged from Huntlyburn. All adults who have been in Huntlyburn for seven or more days are invited to take part. The study is in three parts, described below.

If you think that you would like to take part in this study, please read on. This leaflet will describe what is involved in taking part, and answer some basic questions. If you have more questions, my contact details are attached and I will be glad to answer them.

Part 1

The first stage of taking part is completing questionnaires. I ask you to do this because I want to understand how some of your characteristics affect your experience of being discharged. The questionnaires will be

- A personal information form: This will ask you to give your age, sex, reason for admission, length of admission, number and length of prior admissions.

- The *Hospital Anxiety and Depression Scale* (HADS). This assesses symptoms of anxiety and depression. You will be asked to pick one of four options which best describes your experience of 14 symptoms. For example: I have felt tense or 'wound up' a) Most of the time b) A lot of the time c) From time to time d) Not at all

- The *Significant Others Scale* (SOS). This assesses support from the important people in your life. You will be asked to identify up to seven people, and rate your current and ideal levels of support from them on a scale from 'never' to 'always'.

- The *Relationship Style Questionnaire* (RSQ). This assesses your approach to close relationships. You will be asked to rate 30 statements from 'not at all like me' to 'very much like me'. For example: I worry about being alone.

- The *Personal Beliefs About Illness Questionnaire* (PBIQ). This assesses the type of thoughts or beliefs you have about your mental health. You will be asked to rate 16 statements from 'strongly disagree' to 'strongly agree'. For example: My illness frightens me.

I expect that completing these questionnaires will take around ½ an hour. You can complete them on your own, or if you prefer I can help you before we begin part two.

Part 2

The second stage is an interview. This interview will take place on the ward a day or two before you are discharged. I will be interviewing you. You are welcome to have a staff member or a friend with you. I expect that the interview will take about 1 – 1 ½ hours, but it could be shorter or longer depending on how much you want to say.

The exact questions I ask will depend on the things you say and that other people before you have said. They are likely to include questions like

- What has it been like for you to be in Huntlyburn?
- What are your thoughts about being discharged?
- What do you think will be the best/worst things about the next few weeks?

The interview will be recorded using a digital audio recorder. I will take notes during the interview.

Part 3

The third stage of taking part is another interview. This will be about 4 weeks after you are discharged. This interview will take place at a local health centre, or if you prefer at your home. I will be interviewing you. You are welcome to have someone with you for the interview. I expect that the interview will take about ½ - 1 hour, but it could be shorter or longer.

The exact questions that I ask will depend on the things you said in your first interview. They are likely to include questions like

- How have you found the weeks since you were discharged?
- How did the things you hoped for or worried about come about?

This interview will be also recorded, and I will take notes.

Questions you may have:

Is this 'therapy'?
No. These interviews are for research purposes only. They are not connected to any treatment on the ward or in the community. Although I am interested to hear about any worries or difficulties that are part of being discharged, I will not be able to offer you any personal advice or therapy in the interview. If you feel that you need or

would like psychological therapy, I will be happy to discuss this with you and your staff separately.

Do I have to take part?
No. Taking part is voluntary. If you decide not to take part, your care and legal rights will not be affected. If you do decide to take part you can change your mind at any time. You do not have to give a reason for leaving the study.

What will you do with the information I give you?
I'll be interviewing several people. I'll be comparing what you say to what other people have said. I expect that there will be some similarities between what people say, and some things that are different for each person. I'll be bringing together the similarities into a report about how people experience discharge from Huntlyburn.

Will my contribution be anonymous?
Yes. When you join the study you will be given a false name. Your real name will be on your consent forms. This will be stored securely in the Psychological Services building. All other forms will have your false name on them. When your interviews are typed, identifying information, for example your name, friends' names, place of work etc, will be changed or deleted.

What will happen to the recording?
The original recording will be stored at Psychological Services until after the study is complete. It will then be destroyed.

Is what I say confidential?
The usual limits of confidentiality apply. This means that although most things you could say will be confidential, there are some exceptions. If you told me about a risk to yourself or others that your nurses or doctors were not aware of – for example that you had strong suicidal thoughts, or that a child was likely to be harmed – I would have to pass that information on. I would always try to discuss this with you before I break confidentiality.

Who will know that I have taken part?
On the consent form, I will ask your permission to write to your *GP* and/or your *Mental Health Team Keyworker* to let them know that you are taking part. They will get a copy of this information sheet. This is to avoid confusion about why you are meeting with me after your discharge. If you would prefer that they don't know, you can decide not to sign that section of the form.

Will my comments affect services?
Not directly. For example even if all the people interviewed stated that they wanted a particular change, this would not guarantee that it would happen. However, all the interviews will be fed back to staff and management, and will be taken into account when decisions about the service are made.

Many thanks for reading this leaflet. Please let me, or one of your staff members, know if you would be interested in taking part in this study.

If you have any other questions about this project before, during or after you take part, please contact Jennifer Strachan (Trainee Clinical Psychologist) via 01896 668821 or Jennifer.Strachan@borders.scot.nhs.uk.

Appendix 8: Consent form

Experience of discharge from Huntlyburn

D Clin Psy Thesis 2010, Jennifer Strachan, Trainee Clinical Psychologist

Consent Form

Please initial in the box beside each statement and sign below.

☐ I confirm that I have read and understand the information sheet about this study, and have had the opportunity to ask questions.

☐ I agree to take part in the project.

☐ I understand that my participation is voluntary, and that I am free to withdraw at any time, without giving any reason, without my care or legal rights being affected.

☐ I give my consent to audio recording of the interviews in which I will participate. I understand that transcripts will be anonymised, the recording stored securely and destroyed following completion of the project.

☐ You may contact my GP _____ and/or Community Psychiatric Nurse _____ to advise them of my participation in this project.

Participant:

Name: Signature: Date:

Researcher:

Name: Signature: Date:

If you would like to receive a summary of the results of this study, or be invited to a presentation of the results, please tick here ☐

If you have any questions about this study before, during or after participation, please contact Jenny Strachan (Trainee Clinical Psychologist) on 01896 668821 or at Jennifer.Strachan@borders.scot.nhs.uk.

Appendix 9: Screenshots; line-by-line coding, category, memo, casebook

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JStrachan Thesis Transcript L2
Personal Statement
Project Journal
JStrachan Thesis Transcript F2
ward and stuff. Em... yeah eh.... sometimes when I was there I felt, like I shouldn't have been there,
because there were people in there who were so much worse than me. You know like who had
actually illnesses. Sometimes I felt like, oh I'm just feeling low' I sh- I don't know how to explain. But
then, em... yeah.
##R##
Yeah. Em, how do you think they would make that judgement though, about you know who should or
shouldn't be in?
##F##
I don't know. (nervous laughter) I guess just, by the way that you act. I don't really know, you know
there were people in there with like schizophrenia and stuff like that. [##R## Mmm hmm.] Em, I don't
know really. [##R## Yeah.] But I guess ev- everyone is different so....For me I felt that I should have
been in there. [##R## Yeah.] Yeah.
##R##
Yeah. How did you, I mean, how did it feel then when.... you know when your discharge date was set?
##F##
I was really scared. And I, didn't think I was ready. [##R## Yeah.] Because I kept thinking, em, like,
I've been here two weeks, but, everything that was there when I came in is still out there. [##R##
Mmm hmm.] So, what if I go out there...., I just go back to being how I was. You know? [##R## Yeah.]
And I was I was really scared, I think I was really.... more scared of leaving than I was going in. [##R##
Yeah.] I was really frightened and I just didn't think I was ready. And, em, a couple of days before I
was discharged em, you know I broke down quite a few times in tears and.... I spoke to the, you know
[##R## Yeah.] a few of the nurses and.... em, you know they just said it was about taking, taking it one
day at a time. You know just taking small steps. But it was scary. [##R## Yeah, yeah.] And I wanted
to make, to make sure that I was fully ready to go so that I didn't have to go back in. You know I didn't
want to.... leave and have another, and end up back, so...
staff judgement [about being on ward] based on actions
not being sure how staff make judgements about readiness
staff encouraging one
having preferences about ward staff
stating one's UNreadine
'I knew I needed help'
staff making suggestion
just feeling low = not an 'actual illness'
knowing the outside problems are sti
negative consequences
'I felt like I shouldn't have been there' [the ward]
evaluating needs relative to other patients
taking things one day or
not yet feeling ready to cope with pro
not being ready for discharge
'It's scary coming in and it's scary go
being scared re discharge
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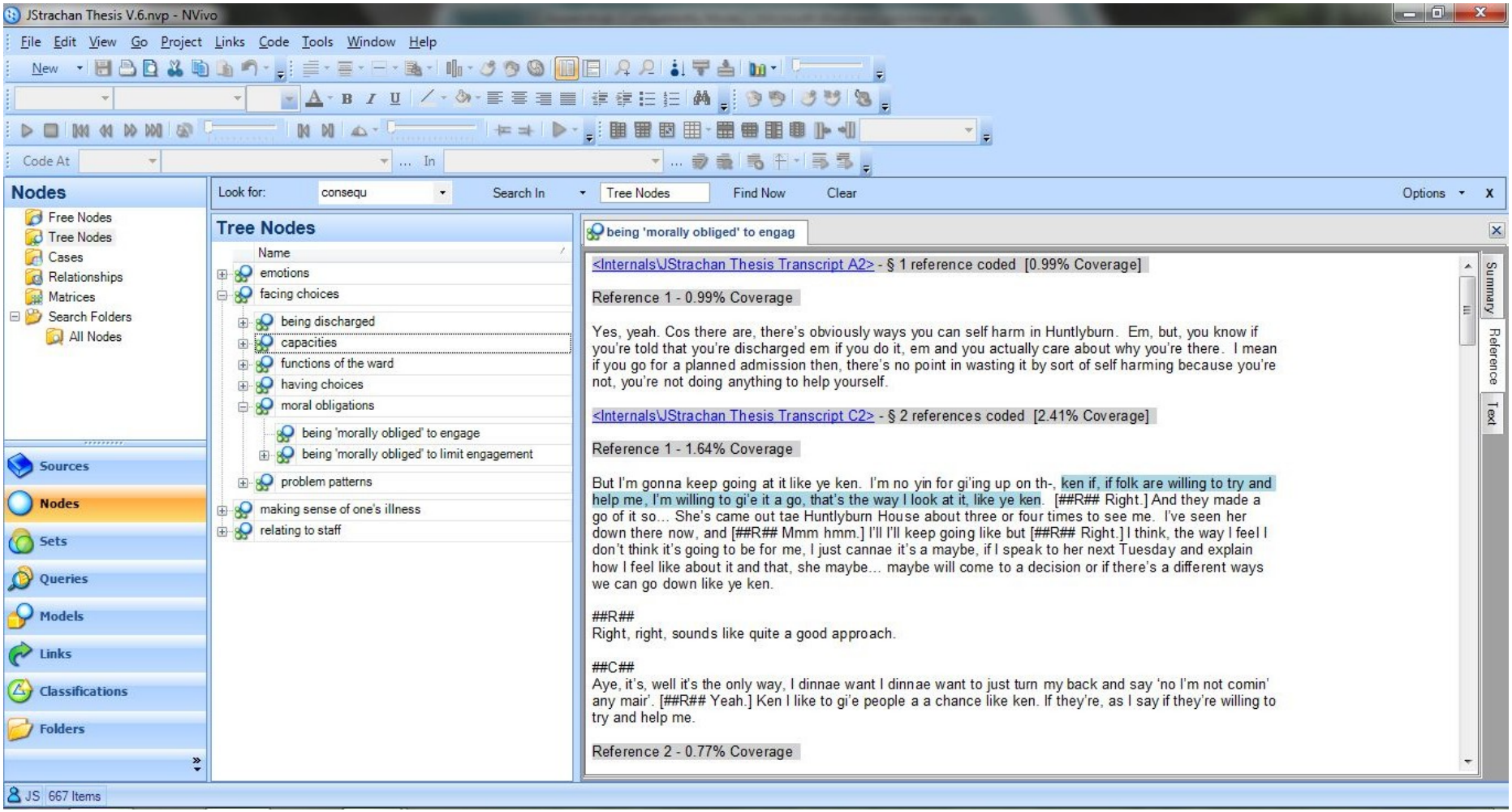
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being 'morally obliged' to limit engagement
problem patterns
making sense of one's illness
relating to staff
being 'morally obliged' to engag
<Internals\JStrachan Thesis Transcript A2> - § 1 reference coded [0.99% Coverage]
Reference 1 - 0.99% Coverage
Yes, yeah. Cos there are, there's obviously ways you can self harm in Huntlyburn. Em, but, you know if you're told that you're discharged em if you do it, em and you actually care about why you're there. I mean if you go for a planned admission then, there's no point in wasting it by sort of self harming because you're not, you're not doing anything to help yourself.
<Internals\JStrachan Thesis Transcript C2> - § 2 references coded [2.41% Coverage]
Reference 1 - 1.64% Coverage
But I'm gonna keep going at it like ye ken. I'm no yin for gi'ing up on th-, ken if, if folk are willing to try and help me, I'm willing to gi'e it a go, that's the way I look at it, like ye ken. [##R## Right.] And they made a go of it so... She's came out tae Huntlyburn House about three or four times to see me. I've seen her down there now, and [##R## Mmm hmm.] I'll I'll keep going like but [##R## Right.] I think, the way I feel I don't think it's going to be for me, I just cannae it's a maybe, if I speak to her next Tuesday and explain how I feel like about it and that, she maybe... maybe will come to a decision or if there's a different ways we can go down like ye ken.
##R##
Right, right, sounds like quite a good approach.
##C##
Aye, it's, well it's the only way, I dinnae want I dinnae want to just turn my back and say 'no I'm not comin' any mair'. [##R## Yeah.] Ken I like to gi'e people a a chance like ken. If they're, as I say if they're willing to try and help me.
Reference 2 - 0.77% Coverage
Summary
Reference
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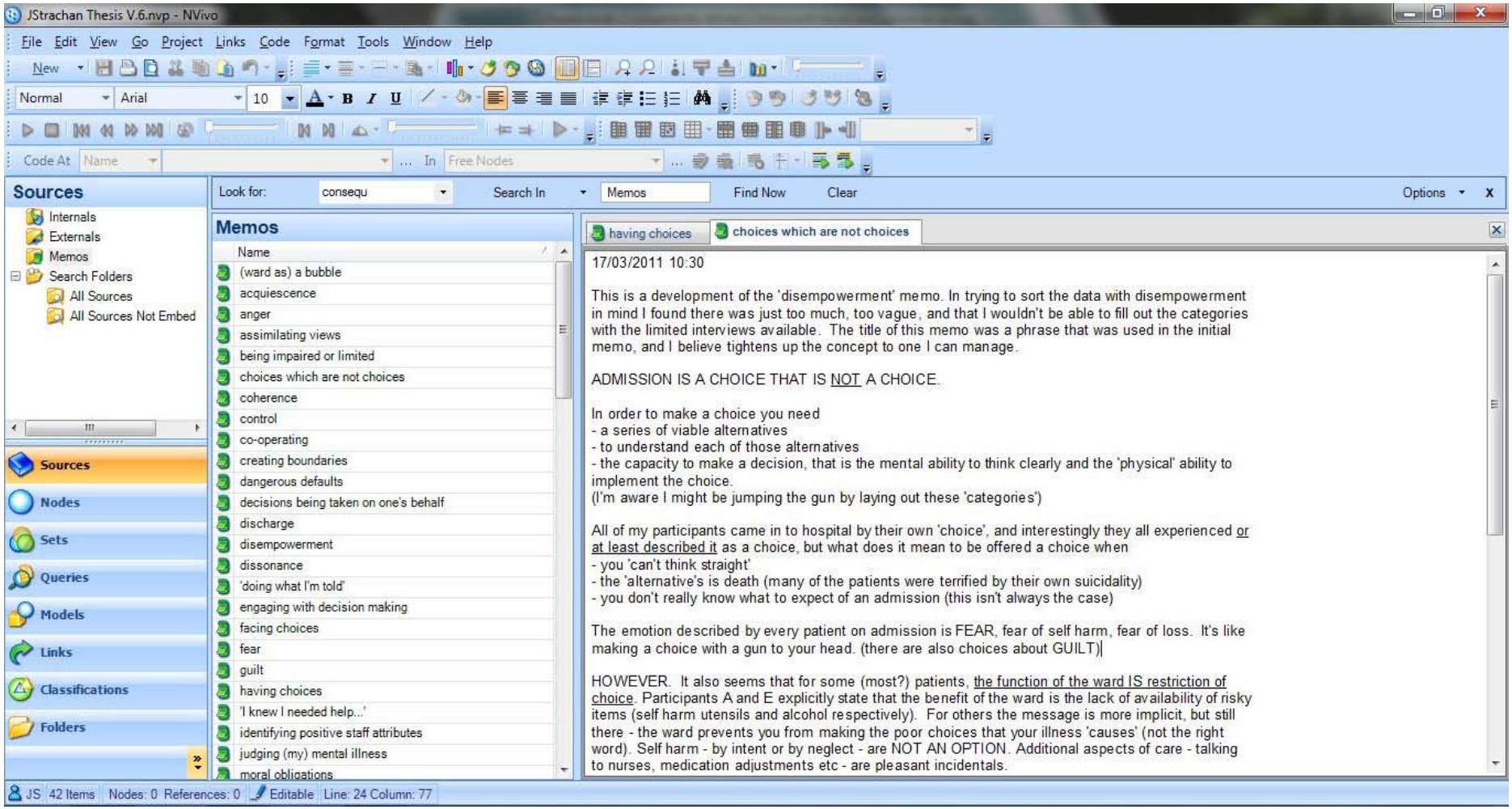
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disempowerment
dissonance
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engaging with decision making
facing choices
fear
guilt
having choices
'I knew I needed help...'
identifying positive staff attributes
judging (my) mental illness
moral obligations
having choices
choices which are not choices
17/03/2011 10:30
This is a development of the 'disempowerment' memo. In trying to sort the data with disempowerment in mind I found there was just too much, too vague, and that I wouldn't be able to fill out the categories with the limited interviews available. The title of this memo was a phrase that was used in the initial memo, and I believe tightens up the concept to one I can manage.
ADMISSION IS A CHOICE THAT IS NOT A CHOICE.
In order to make a choice you need
- a series of viable alternatives
- to understand each of those alternatives
- the capacity to make a decision, that is the mental ability to think clearly and the 'physical' ability to implement the choice.
(I'm aware I might be jumping the gun by laying out these 'categories')
All of my participants came in to hospital by their own 'choice', and interestingly they all experienced or at least described it as a choice, but what does it mean to be offered a choice when
- you 'can't think straight'
- the 'alternative's is death (many of the patients were terrified by their own suicidality)
- you don't really know what to expect of an admission (this isn't always the case)
The emotion described by every patient on admission is FEAR, fear of self harm, fear of loss. It's like making a choice with a gun to your head. (there are also choices about GUILT)
HOWEVER. It also seems that for some (most?) patients, the function of the ward IS restriction of choice. Participants A and E explicitly state that the benefit of the ward is the lack of availability of risky items (self harm utensils and alcohol respectively). For others the message is more implicit, but still there - the ward prevents you from making the poor choices that your illness 'causes' (not the right word). Self harm - by intent or by neglect - are NOT AN OPTION. Additional aspects of care - talking to nurses, medication adjustments etc - are pleasant incidentals.
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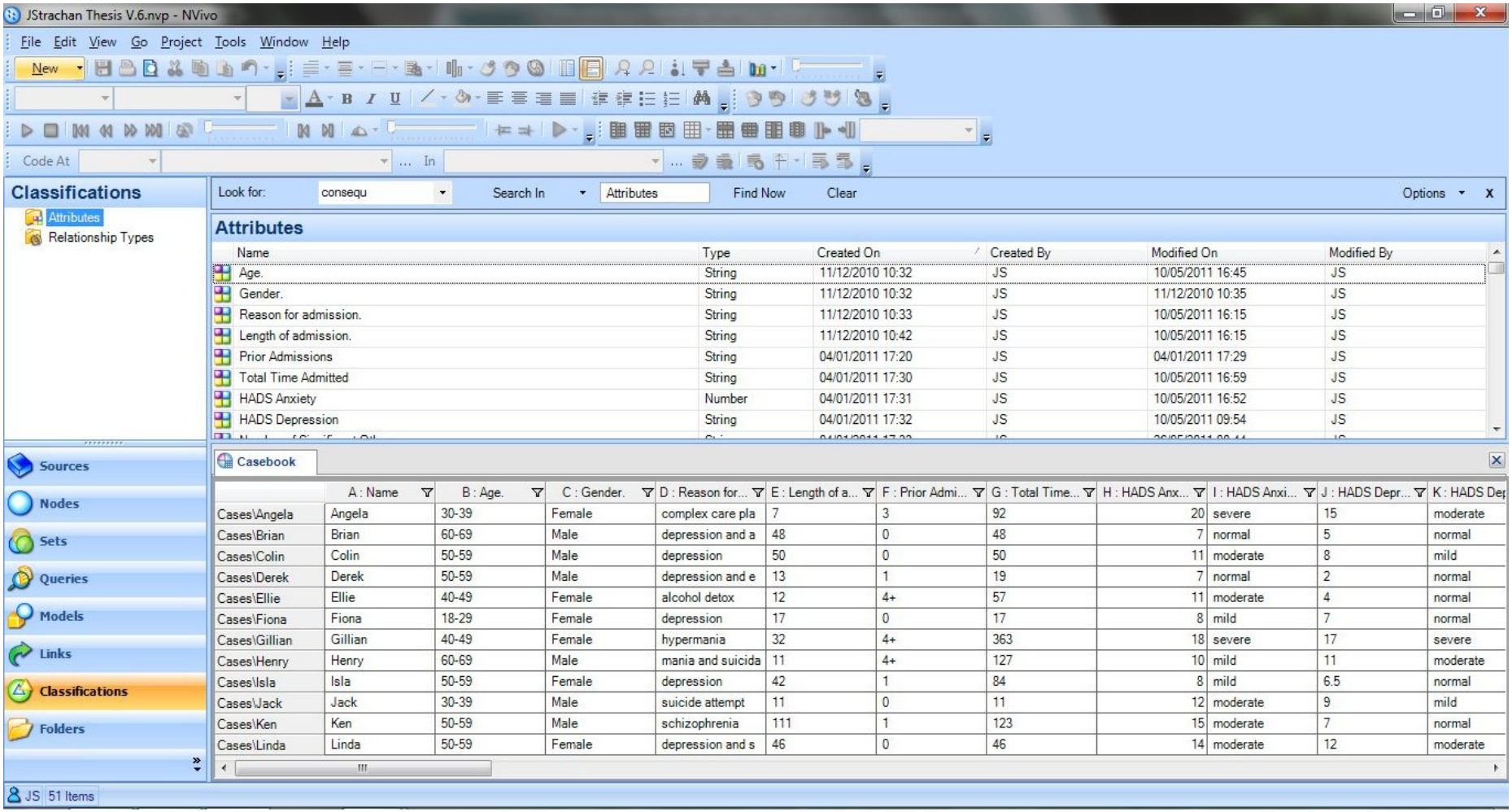
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Reason for admission.
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11/12/2010 10:33
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10/05/2011 16:15
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Length of admission.
String
11/12/2010 10:42
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Prior Admissions
String
04/01/2011 17:20
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Total Time Admitted
String
04/01/2011 17:30
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10/05/2011 16:59
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HADS Anxiety
Number
04/01/2011 17:31
JS
10/05/2011 16:52
JS
HADS Depression
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C : Gender.
D : Reason for...
E : Length of a...
F : Prior Admi...
G : Total Time...
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I : HADS Anxi...
J : HADS Depr...
K : HADS Dep
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51 Items

Appendix 10: Ethics responses

Lothian NHS Board

South East Scotland Research
Ethics Committee 03
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000
Fax 0131 536 9088

www.nhslothian.scot.nhs.uk

Enquiries to Joyce Clearie
Extension 35674
Direct Line 0131 465 5674
Email joyce.clearie@nhslothian.scot.nhs.uk

22 July 2010

Miss Jennifer Strachan
Trainee Clinical Psychologist
NHS Borders
Psychological Services
12-14 Roxburgh Street
Galashiels
TD1 1PF

Dear Miss Strachan

Study Title: **Patient experience of discharge from an inpatient mental health unit: a mixed-methods approach**
REC reference number: **10/S1103/39**
Protocol number: **n/a**

The Research Ethics Committee reviewed the above application at the meeting held on 21 July 2010. Thank you for attending to discuss the study.

Ethical opinion

The Committee noted that this study would consider the experiences of patients being discharged from Huntlyburn – NHS Borders acute mental health unit. Participants will be interviewed about their perceptions of the discharge process immediately before their discharge and again four weeks after discharge. The Committee discussed the transcript validation and wondered whether this was necessary as it could result in the interview being invalid. The Committee also raised concern that the interviews would be taking place at the homes of the participants and requested clarification that appropriate precautions would be taken. The Committee welcomed Miss Strachan to the meeting. The Committee asked about the transcript validation process. Miss Strachan explained that this was included to provide additional assurance that consent was informed. The Committee suggested discussing whether this process should be included with her supervisor. It was also suggested that the transcript could be offered to participants for their information.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

Headquarters
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Dr Charles J Winstanley
Chief Executive Professor James J Barbour O.B.E.
Lothian NHS Board is the common name of Lothian Health Board

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- Confirm that appropriate precautions will take place for the home visits.
- Discuss the possibility of removing the transcript validation section of the research with your supervisor.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Investigator CV	CI	11 June 2010
Protocol	1	11 June 2010
REC application		11 June 2010
Covering Letter		11 June 2010
Interview Schedules/Topic Guides	1	11 June 2010
Questionnaire: SOS		
Advertisement		11 June 2010
GP/Consultant Information Sheets	1	11 June 2010
Participant Information Sheet: PIS	1	11 June 2010
Participant Consent Form: PCF	1	11 June 2010
Participant Consent Form: PCF Transcription val 1	Transcription val 1	11 June 2010
Participant Consent Form: PCF Transcription val 2	Transcription val 2	11 June 2010
Questionnaire: RSQ		
Questionnaire: PBIQ		
Questionnaire: HADS		
Questionnaire: Personal Data		11 June 2010

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/S1103/39	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Christine West
Chair

Email: joyce.clearie@nhslothian.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *Ms Gemma Watson*

South East Scotland Research Ethics Committee 03

Attendance at Committee meeting on 21 July 2010

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mrs Fiona Barry	Psychologist	Yes	
Mrs Pat Drewitt	Dermatologist	No	
Reverend Denise Herbert	Rector	Yes	
Dr Yann Maidment	General Dental Practitioner	No	
Ms Joanne Mair		Yes	
Mr Nigel Masterton	Company Director	Yes	
Dr Maureen Mcmillan	Retired	No	
Mr Hugh Olson	Lawyer	Yes	
Mr Warwick Taylor	Retired	Yes	
Mrs Anne Tod	Retired	No	
Mrs Hilary Vandore	Retired	~~No~~ Yes	
Dr Hester Ward	Public Health Consultant	No	
Dr Christine West	Gynaecology	Yes	
Mr Vipin Zamvar	Cardiothoracic Surgeon	No	

Lothian NHS Board

South East Scotland Research
Ethics Committee 03
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000
Fax 0131 536 9088

www.nhslothian.scot.nhs.uk
Date
Our Ref
Enquiries to Joyce Clearie
Extension 35674
Direct Line 0131 465 5674
Email joyce.clearie@nhslothian.scot.nhs.uk

30 July 2010

Ms Jennifer Strachan
Trainee Clinical Psychologist
Psychological Services
12-14 Roxburgh Street
Galashiels
TD1 1PF

Dear Ms Strachan

Full title of study: **Patient experience of discharge from an inpatient mental health unit: a mixed-methods approach**
REC reference number: **10/S1103/39**
Protocol number:
EudraCT number:

Thank you for your letter of 29 July 2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 21 July 2010. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Protocol	2	29 July 2010
REC application revised		
Covering Letter		29 July 2010
Participant Information Sheet	2	29 July 2010
Participant Consent Form	2	29 July 2010

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

10/S1103/39	**Please quote this number on all correspondence**

Yours sincerely

Ms Joyce Clearie
Committee Co-ordinator

E-mail: joyce.clearie@nhslothian.scot.nhs.uk

Copy to:

Ms Gemma Watson,
[R&D office for NHS care organisation at lead site]

NHS Borders

Research Administration
Clinical Governance

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Borders General Hospital
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Jennifer Strachan
Psychological Services
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Galashiels
TD1 1PF

Date 20 August 2010

Our Ref 10/BORD/15

Enquiries to Claire Simpson
Extension 01896 826718
Email research.governance@borders.scot.nhs.uk

Dear Jennifer

Patient experience of discharge from an inpatient mental health unit

Thank you for sending details of your study to NHS Borders. I can confirm that the Research Governance Committee have reviewed the documentation, and on this basis I am pleased to inform you that this study has management approval for commencement within NHS Borders.

It is a condition of approval that everyone involved in this study abides by the guidelines/protocols implemented by NHS Borders with respect to confidentiality and Research Governance. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek advice if you are unsure.

Please advise the R&D Office immediately of any changes to the project such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Borders.

Please also inform this office when recruitment has closed and when the study has been completed, quoting the reference number stated above in all correspondence.

Amendments to the protocol will require approval from the ethics committee that approved your study. Please inform this office when recruitment has closed and when the study has been completed. Please quote the reference number stated above in all correspondence.

May I take this opportunity to wish you every success with your project. Please do not hesitate to contact the R&D Office should you require any further assistance.

Yours sincerely

Thomas Cripps

Thomas Cripps
Associate Medical Director (Clinical Governance)

Appendix 11: Coding Structure

Tree Nodes

Name	Sources	References
emotions	0	0
feeling fearful	21	85
feeling guilty	18	53
facing choices	0	0
being discharged	18	64
capacities	0	0
being coherent	17	61
having control	18	66
functions of the ward	0	0
creating boundaries	18	58
being a bubble	8	19
'moulding you back into shap	19	43
having choices	20	58
moral obligations	0	0
being 'morally obliged' to eng	10	17
being 'morally obliged' to limi	14	26
problem patterns	0	0
dangerous defaults	23	85
unwanted wants	21	88
making sense of one's illness	1	1
'am I really ever going to feel well ag	20	79
being limited or impaired	21	97
relying on others	10	25
being vulnerable	23	99
judging (my) mental illness	19	62
relating to staff	0	0
developing a trust relationship	10	13
engaging	0	0
being uncooperative	15	26
cooperating	18	57
assimilating views	8	14
decisions being taken on on	15	42
'doing what I'm told'	2	5
not communicating views	12	20
resigning oneself	13	27
co-operating	19	53